

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 16. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 4 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, Cremation, or Removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 5 9 2 6								
1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a DATE KNOWN OF DEATH ESTI- MATED		MONTH	DAY	YEAR	2b HOUR	
		Griselda				W.				Addison		<input checked="" type="checkbox"/>		12/	31/	87	M	
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		MONTH		DAY		2d. HOUR
Female		Black		12 07 1907		80 yrs.						<input checked="" type="checkbox"/>		12/	31/	87	3:45 p.m.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH										
Maryland		U. S. A.						Howard County, MD										
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY										
Columbia		6557 Quiet Hours				Homemaker		Home										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		Columbia, Maryland								
Maryland		How		Columbia				6557 Quiet Hours Apt. T-1 21045										
14a. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST								
Isaac		M.		Turner		Nellie		E.		Johnson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.				17. INFORMANT		ADDRESS										
(If Yes, give war or dates) No.		214-16-3291-A				Phillip L. Turner		Baltimore, Maryland										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		Arteriosclerotic Cardiovascular Disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF																
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause</u> lost.																		
(b)		DUE TO, OR AS A CONSEQUENCE OF																
(c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?						
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
		P.M. 19																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																		
22b. TITLE (SPECIFY) Assistant MEDICAL EXAMINER Dennis F. Smyth, M.D.																		
DATE SIGNED 1/1/88																		
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Balto., Md. 21201																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE								
Burial		1/06/1988		Md. National Mem. Park		Laurel,				Md.								
24. FUNERAL DIRECTOR NAME		ADDRESS																
25a. DATE REC'D. BY REGISTRY		25b. REGISTRATION SIGNATURE																
JAN 7 1988		Lea Sanders-Randall																

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper from pages 2 & 3 and be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the cause of death will be considered as being induced by such an event.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8735927	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2d. DATE OF DEATH		MONTH	DAY	YEAR	2d HOUR
JOSEPH EARL AHERN, SR.								11 12 87					5:00 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White		MONTH 10 DAY 19 YEAR 10			77		MONTHS YRS		HOURS MIN.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Maryland		U.S.A.					Howard County						
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Elkridge		6304 Montgomery Road					Purchasing Agent		Electronic Co.				
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Elkridge			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6304 Montgomery Road		21227		
14. FATHER'S NAME FIRST John		MIDDLE		15. MOTHER'S MAIDEN NAME LAST Ahern Frances							LAST Dorsch		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS		21227				
NO		212-10-6160		Gertrude M. Ahern 6304 Montgomery Rd.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC COLON CARCINOMA												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)													
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE					
22a. I certify that (I) (we) attended the deceased from MAY 21, 1981, to NOVEMBER 12, 1987, that (I) (we) last saw the deceased alive on SEPTEMBER 30, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not touch the body after death.													
22b. SIGNATURE <i>Diana H. Griffiths</i>		22c. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 11/13/87							
23e. THE PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		Oncology Dept. St. Agnes Hosp.									
Diana H. Griffiths													
23f. BURIAL, CREMATION, REMOVAL (SPECIFY)		23g. DATE		23h. NAME OF CEMETERY OR CREMATORIUM		23i. LOCATION CITY OR TOWN							
Burial		11/16/87		Sacred Heart Cemetery		Dundalk							
24. FUNERAL DIRECTOR NAME		ADDRESS		21229		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Hubbard Funeral Home, Inc.		4107 Wilkens Avenue				NOV 16 1987		<i>Julia Davidson-Landale</i>					

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH35928
REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 2 TO THE FUNERAL DIRECTOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR			
MARTHA White Butler				ARRINGTON			<input checked="" type="checkbox"/>	12	11	19	87			
3c. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS	8. IF UNDER 24 HRS. DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR			
Female	Caucasian	Sept. 3, 1939	48				<input checked="" type="checkbox"/>	12	11	19	87			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
North Carolina		U.S.A.					Howard County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING HRS.		12b. KIND OF BUSINESS OR INDUSTRY							
Columbia		5711 Margrove Mews			Bakery Clerk		Giant Foods							
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS									
Maryland	Howard	Columbia	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5711 Margrove Mews 21045									
14. FATHER'S NAME FIRST		MIDDLE	LAST		15. MOTHER'S MAIDEN NAME FIRST		LAST							
George			Butler		Odell		White							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
No		240-60-3698		(son) Rt. 3, Box 506										
William Stocks		Williamston, NC 27892												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun wound of thigh DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?									
					<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
9 XXX 12-11-1987				Subject shot.										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET 5711 Margrove Mews, Columbia, Howard,		CITY OR TOWN COUNTY STATE								
home														
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER								
EXAMINER'S NAME TYPE OR PRINT		ADDRESS		111 Penn St., Balto., MD 21201		DATE SIGNED 12-11-87								
23a. BURIAL, CREMATION, REMOVAL SPECIFY		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN Leniston, North Carolina		COUNTY STATE						
Burial		Dec. 17, 87		Butler Family Cemetery										
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
Capitol Funeral Service, Falls Church, VA				DEC 16 1987		Julia Gordon-Laddell								

referred to

Replies should be made to:

A.E.U. Serials Section

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Information which contains trade secrets may be referred to by the Bureau of Investigation.

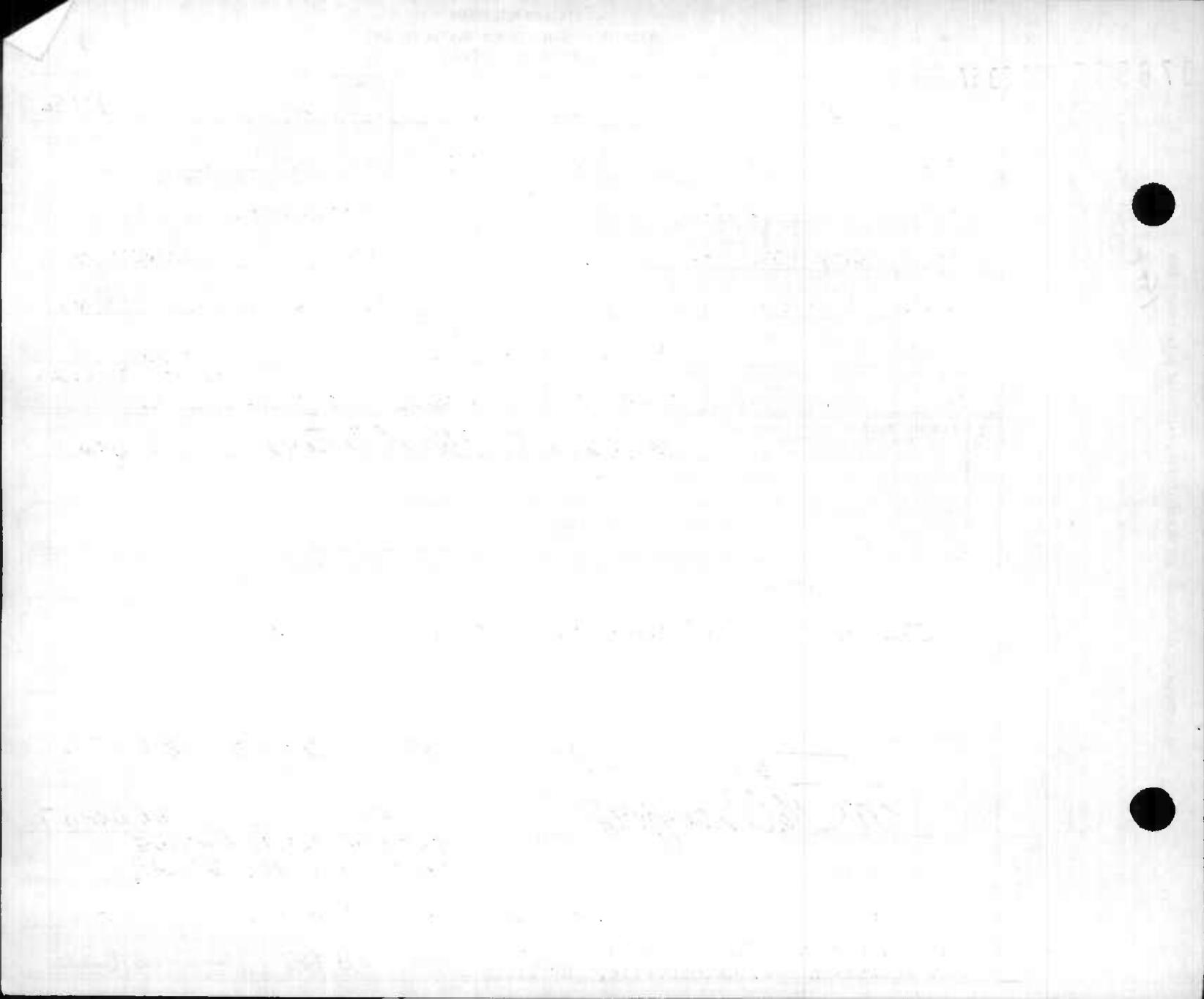
NY, DO NOT USE THIS COPY FOR INTERNAL USE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene, Office to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to filing.

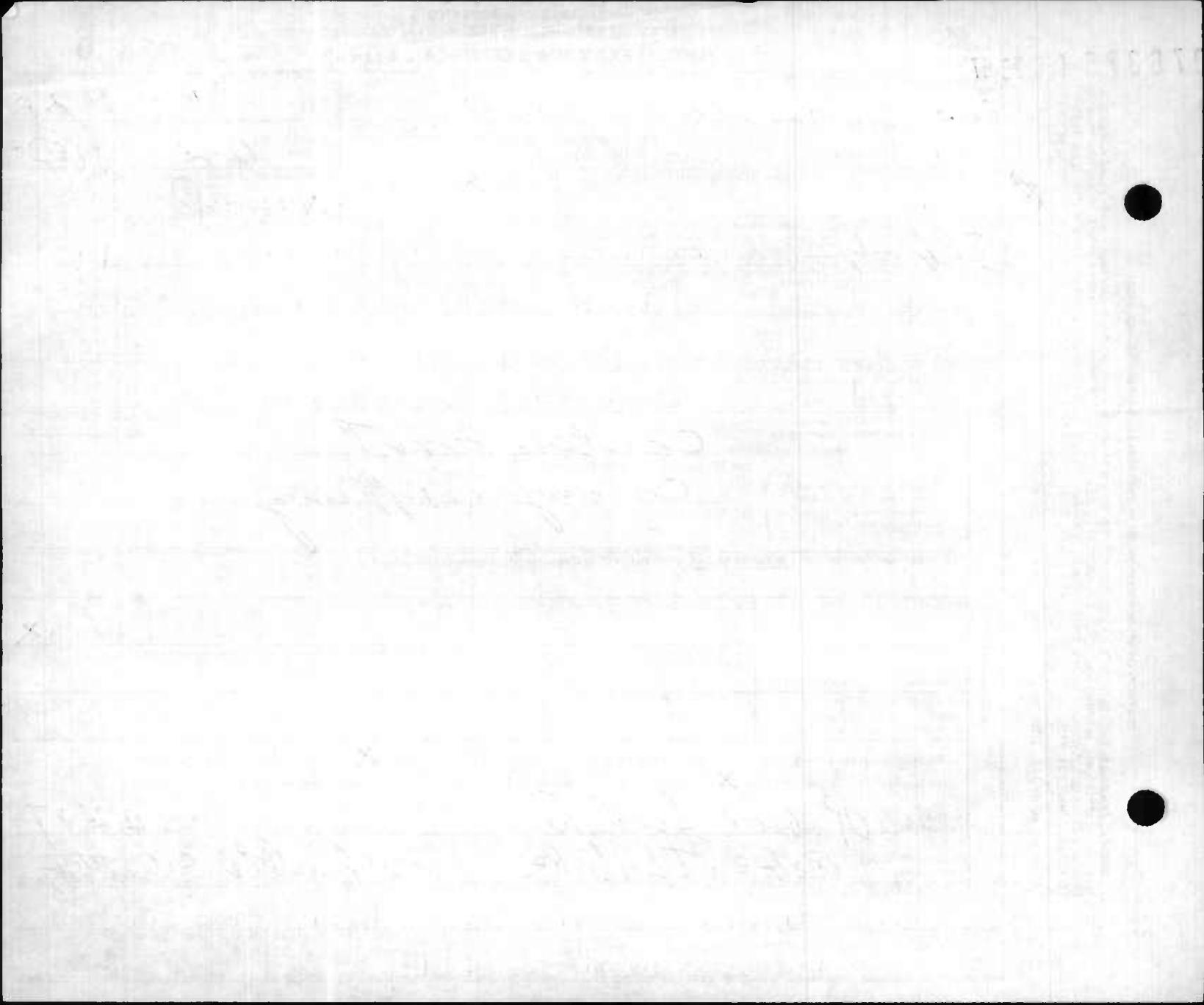
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 35929	
DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d DATE OF DEATH	MONTH	DAY	YEAR	2d HOUR	
FRANK					BAKER JR.	December	25.	1987		1:15 PM	
3. SEX		4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		# UNDER 24 HRS	
Male		White	March 19, 1913			74 YRS		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.A.					Howard County MD.				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY				
Ellicott City		3113 The Oaks Rd.			CEO		MONUMENTAL CORP.				
13a STATE		13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE		ADDRESS			
Maryland		Howard	Ellicott	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3113 The Oaks Rd. 21043		Ellicott City, MD 21043			
14 FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST				
Frank			Baker Sr.	Virginia			Martin				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.			17 INFORMANT		ADDRESS				
Yes		World War II 213-03-3673			Miriam Baker		3113 The Oaks Rd.				
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant Glioblastoma</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>											
DOUE TO, OR AS A CONSEQUENCE OF { (b) DOUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>none</u>											
19a DATE OF OPERATION <u>Jan 1987</u>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Malignant Glioblastoma</u>			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a I certify that (I) <u>the hospital</u> attended the deceased from <u>JAN 1980</u> to <u>DEC 25 1987</u> , that (I) <u>we</u> lost saw the deceased alive on <u>Dec 22 1987</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) <u>not</u> view the body after death.										22c DATE SIGNED <u>26 Dec 87</u>	
22b SIGNATURE <u>MC Gallager Jr</u>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. Wilmer Gallagher</u>		22e ADDRESS <u>3455 WILKENS AVENUE BALTIMORE, MD 21229</u>									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b DATE <u>12/29/87</u>		23c NAME OF CEMETERY OR CREMATORIAL <u>Loudon Park Cemetery</u>		23d LOCATION CITY OR TOWN <u>Baltimore City</u>		COUNTY		STATE <u>Maryland</u>	
24 FUNERAL DIRECTOR <u>LeRoy M. & Russell C. Witzke</u> <u>Funeral Home</u> <u>1630 Edmondson Ave. Catonsville, MD 21228</u>		25a DATE REC'D. BY REGISTRAR <u>DEC 29 1987</u>		25b REGISTRAR'S SIGNATURE <u>Julia Dawson Radke</u>							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM BM-1A. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE TORN OUT AND REMOVED AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 35930		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a. DATE KNOWN OF DEATH ESTIMATED			2b. MONTH DAY YEAR	2b. HOUR AM PM		
MELVIN			KENNETH	BECK, SR.				<input type="checkbox"/> 12 26 87			19			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.									
MALE	WHITE	5 12 26	61 yrs.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Newark					
10. CITY OR TOWN OF DEATH Elkridge			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6408 Loudon Avenue			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician			12b. KIND OF BUSINESS OR INDUSTRY Electric Union					
13a. STATE Maryland			13b. COUNTY Howard			13c. CITY OR TOWN Elkridge			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 6408 Loudon Avenue 21227		
14. FATHER'S NAME FIRST Unknown MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE LAST Schaub											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WW II			17. INFORMANT Doris Beck			ADDRESS 6408 Loudon Ave. 21227					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma breast</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <i>Coronary insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE <i>Robert Ludlum</i>			M.D. _____			TITLE (SPECIFY) MEDICAL EXAMINER			DATE SIGNED 12-26-87					
EXAMINER'S NAME (TYPE OR PRINT) <i>Robert Ludlum</i>			ADDRESS <i>9055 Herbert St. Elkridge</i>			23d. LOCATION CITY OR TOWN Elkridge			COUNTY Howard			STATE Maryland		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/30/87			23c. NAME OF CEMETERY OR CREMATORIUM Meadowridge Mem. Pk.			23d. LOCATION CITY OR TOWN Elkridge					
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.			ADDRESS 21229 4107 Wilkins Ave.			25a. DATE REC'D. BY REGISTRAR DEC 28 1987			25b. REGISTRAR'S SIGNATURE <i>John F. Ladd</i>					
DHMH - 17 (VR A15 ME (5))														



078179 JAN 13 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return certificate pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial; cremation, or embalming.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
87 REG. NO. 35931													
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
Calvin Lee Bloom						December 26, 1987					4:20 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		White		Month Day Year June 17, 1909			78 YRS 6 9						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard Co., MD						
Maryland		U.S.A.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mt. Airy 16529 Bloom's Lane										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter	
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Mt. Airy			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 16529 Bloom's Lane, 21771		
14. FATHER'S NAME FIRST Arthur		MIDDLE L.		LAST Bloom			15. MOTHER'S MAIDEN NAME FIRST Celetta				MIDDLE Frances		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-14-7681		17. INFORMANT 322 E. Watersville Road Calvin L. Bloom, Jr., Mt. Airy, 21771									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) lung Cancer APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF 6 mo Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11-86, 19_____, to Dec 26, 1987, that (I) (we) last saw the deceased alive on 9-5 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE John Morgan		MD DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12-28-87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N K Rajpara, M.D.		22e. ADDRESS 224 Wash. Hgts. Med. Ctr. Westminster, MD 21157											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-29-1987		23c. NAME OF CEMETERY OR CREMATORIAL Poplar Springs			23d. LOCATION CITY OR TOWN		COUNTY Howard, Md.		STATE		
24. FUNERAL DIRECTOR Charles W. Burrier, Jr., Sykesville, Md.		25a. DATE REC'D. BY REGISTRAR DEC 30 1987			25b. REGISTRAR'S SIGNATURE Julia Neison-Burrier								

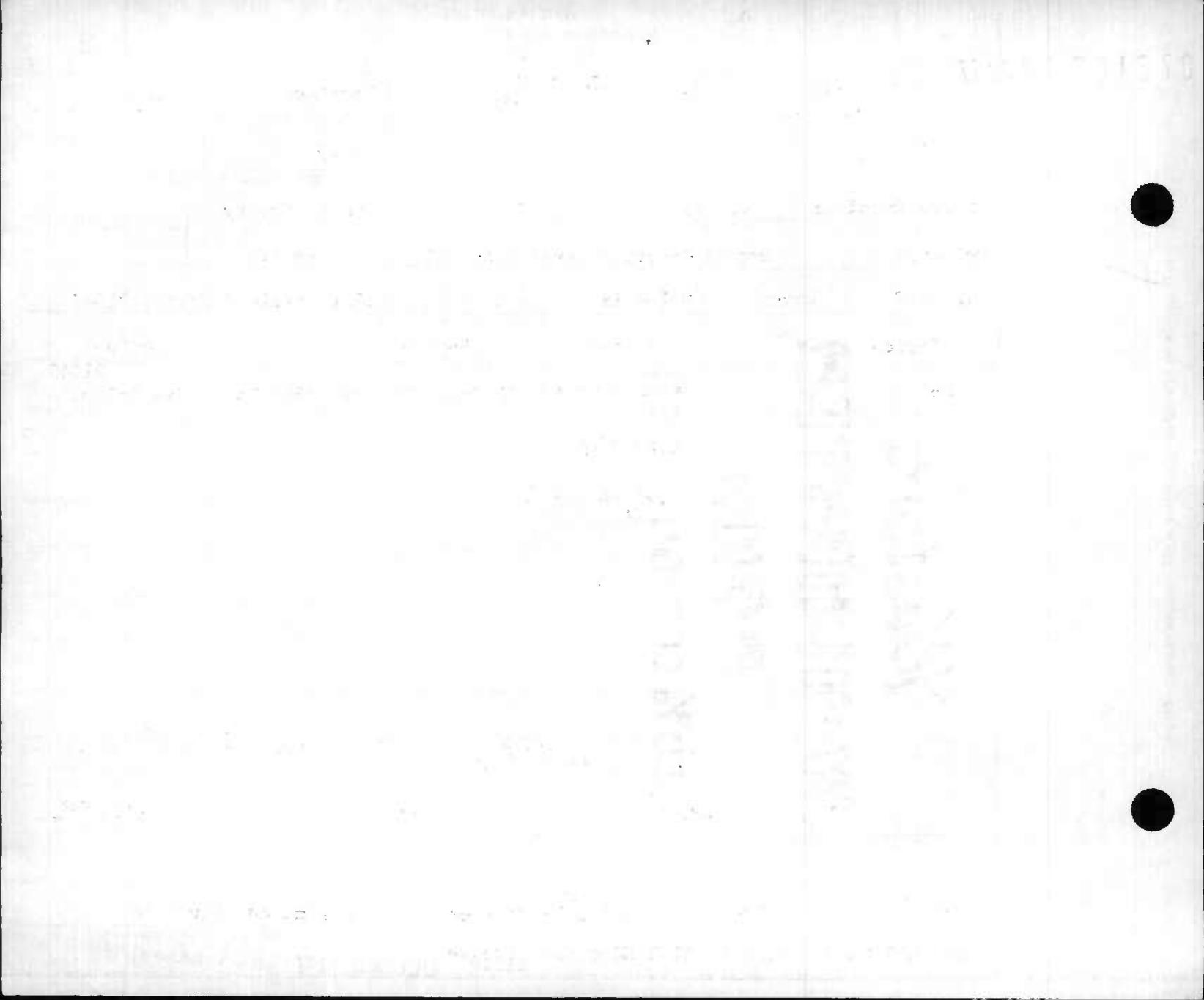
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
8735932 REG. NO.											
1. FOR 1 - STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			MIDDLE	BOONE Boone			2. DATE OF DEATH December 12 22 87	MONTH DAY YEAR	2b HOUR 12 noon	
	ANNIE Annie			m							
3. SEX Female	4. RACE Black			5. DATE OF BIRTH MONTH DAY YEAR 8 22 97			6. AGE (IN YEARS LAST BIRTHDAY) 90	IF UNDER 1 YEAR MONTHS DAYS		2b HOUR IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard County				MD.
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland	13b. COUNTY Howard	13c. CITY OR TOWN Columbia	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 6150 Foreland Garth 21045					
14. FATHER'S NAME FIRST Issiah	MIDDLE	LAST Hunter	15. MOTHER'S MAIDEN NAME FIRST Sophie			MIDDLE	LAST Dildy				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 556-80-8274			17. INFORMANT AlonzaM. Dickson			ADDRESS 21045 Young Sea Columbia				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Stroke											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertension											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Bronow Failure											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I this hospital) attended the deceased from 11/14 1987 to 12/22 1987. That (I we) last saw the deceased alive on 11/22 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did/did not view the body after death.											
22b. SIGNATURE <i>Jerry E. Stetler</i>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED 11/22/87	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 12-28-87		23c. NAME OF CEMETERY OR CREMATORIAL Lincoln Cemetery			23d. LOCATION CITY OR TOWN Portsmouth, Virginia		COUNTY	STATE	
24. FUNERAL DIRECTOR Marshall W. Jones, Jr FH 4101 Edmondson Avenue 21229		25a. DATE REC'D. BY REGISTRAR DEC 24 1987			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>						
DHMH - 16 60M 7/84 (VRA 15, 4)											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
6735933											REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
REGINA RUTH BRALL						NOVEMBER 15, 1987						2:15 AM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		WHITE		MONTH DAY YEAR			71			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
NEW YORK		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			HOWARD COUNTY								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
COLUMBIA		LORIEN NURSING HOME			HOUSEWIFE			HOMEMAKER							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS							
MARYLAND		HOWARD		COLUMBIA		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8856 YOUNG SEA PL. (21045)							
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST					
ALBERT				FISHER		ROSE				HECHT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT		17. ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>aspiration pneumonia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO		129-10-6899		ARON BRALL		8856 YOUNG SEA PL.		COLUMBIA, MD. (21045)		<u>acute onset</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) <u>opharyngeal dysphagia</u>		DUE TO, OR AS A CONSEQUENCE OF <u>multiple sclerosis</u>		months		DUE TO, OR AS A CONSEQUENCE OF (c) <u>multiple sclerosis</u>		years.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) this hospital attended the deceased from <u>7/9</u> , 19 <u>87</u> , to <u>4/15</u> , 19 <u>87</u> , that (II) we last saw the deceased alive on <u>11/15</u> , 19 <u>87</u> , and that in (my) our opinion death occurred on the date and hour and from the causes stated above (I) we (did) (did not) view the body after death.															
22b. SIGNATURE <u>KOLODRUBETZ</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/16/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>KOLODRUBETZ</u>		22e. ADDRESS Suite 103 2850 Ridge Rd Ellicott City MD													
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 11/17/87		23c. NAME OF CEMETERY OR CREMATORIUM NEW MONTEFIORE CEM.		23d. LOCATION CITY OR TOWN PINELAWN, N.Y.		23e. COUNTY STATE 21043							
24. FUNERAL DIRECTOR NAME 6010 REISTERSTOWN RD. BALTO., MD. (21215)		25a. DATE REC'D. BY REGISTRAR NOV 18 1987		25b. REGISTRAR'S SIGNATURE <u>John R. Hecht</u>											
DHMH - 16 50M 1/81 (VRA 15, 4)															

055850
RECEIVED

585850
RECEIVED

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-EN-3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, TURN OVER TO FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS.

BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. RELEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED				MONTH	DAY	YEAR	2b. HOUR	
Steven				Michael		Breining	<input checked="" type="checkbox"/> 11/ 17/19 87				MONTH	DAY	YEAR	2d. HOUR	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD				MONTH	DAY	YEAR	2d. HOUR		
Male	white	Oct. 18, 1957 30	YRS.			<input checked="" type="checkbox"/> 11/ 19/19 87				9. BALTIMORE CITY OR COUNTY OF DEATH	Howard County,				
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Pennsylvania				USA				Cloudleap Court - 8790				12b. KIND OF BUSINESS OR INDUSTRY			
10. CITY OR TOWN OF DEATH Columbia												Electrical			
13a. STATE Maryland				13b. COUNTY Harford		13c. CITY OR TOWN Abingdon		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 2507 Red Maple Drive 21009			
14. FATHER'S NAME Paul				MIDDLE Jerome		LAST Breining		15. MOTHER'S MAIDEN NAME Donna				LAST Marie Grager			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 216-54-7002				17. INFORMANT Paul J. Breining, 2507 Red Maple Drive				ADDRESS Abingdon, Md. 21009			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY ESTIMATED P.M. 11/ 17/ 87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self inflicted wound							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION STREET 8790 Cloudleap Court, Columbia, Howard, Md.				CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, which death resulted from Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Dennis F. Smith, M.D.</i>												HEAD ONLY Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smith, M.D.												TITLE (SPECIFY) Assistant MEDICAL EXAMINER			
ADDRESS 111 Penn St., Balto., Md. 21201												DATE SIGNED 11/20/87			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Nov. 23, 1987				23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens				23d. LOCATION CITY OR TOWN Bel Air			
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009				ADDRESS				25a. DATE REC'D. BY REGISTRAR NOV 24 1987				25b. REGISTRAR'S SIGNATURE <i>Julia Sander-Lindner</i>			

WISCONSIN

THURSDAY 10 MAY 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and attested to in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked "G" item 18 shows any injury, or other traumatic event, the medical certification section must be filled out once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
8735935 REG. NO.											
1 - STATE REGISTRAR			FIRSt			MIDDLE			LAST		
1. DECEASED NAME (TYPE OR PRINT)			EVA			L.			BRUMLEY		
2. SEX		3. RACE		4. DATE OF BIRTH			5. AGE (IN YEARS LAST BIRTHDAY)			6. HOUR	
FEMALE		WHITE		MONTH 09 DAY 10 YEAR 97			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
GEORGIA		U.S.A.					HOWARD COUNTY			MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									
COLUMBIA		HOWARD COUNTY GENERAL HOSPITAL									
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE MARYLAND		13c. COUNTY HOWARD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE APT 304 10799 HICKORY RIDGE ROAD 21044		
14. FATHER'S NAME		FIRST WILLIAM		MIDDLE		15. MOTHER'S MAIDEN NAME			16. KIND OF BUSINESS OR INDUSTRY OWN HOME		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. NO		17. INFORMANT			ADDRESS 21045				
		215-50-9998		SUSAN PIE			BRETT LANE			COLUMBIA MD	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary insufficiency cardiopulmonary arrest											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF (b) Muscle wasting.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Hepatic bleeding bronchial ulcer; Acute renal failure.											
19a. DATE OF OPERATION 9-16-87 10-12-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Recurvatus Diverticulitis Bleeding colon.			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 10-30-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE A. Divakaruni		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 10-30-87			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) A. DIVAKARUNI		22f. ADDRESS 10806 Hickory Ridge Road, Columbia MD 21044									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 11/02/87			23c. NAME OF CEMETERY OR CREMATORIAL WESTVIEW CREMATORIAL			23d. LOCATION CITY OR TOWN WESTVIEW BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR NAME LEROY M & RUSSELL C WITZKE FUNERAL HOME 1630 EDMONDSON AVE CATONSVILLE MD 21228		24a. DATE REC'D. BY REGISTRAR NOV 03 1987			24b. REGISTRAR'S SIGNATURE Julie Deidra Rendall						

8205012500



073569 DEC -

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, attach a separate sheet of paper and describe in detail.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1- STATE REGISTRAR 87		SHARON R. CALIFANO			87 35936			REG. NO.					
1a. DECEASED NAME (TYPE OR PRINT)		FIRST SHARON	MIDDLE R.	LAST CALIFANO	2a. DATE OF DEATH MONTH NOV			DAY 23	YEAR 1987	2b. HOUR 900 AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 8 DAY 12 YEAR 54			6. AGE (IN YEARS LAST BIRTHDAY) MONTHS 33		IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS HOURS 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD		
10. CITY OR TOWN OF DEATH COLUMBIA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD COUNTY GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY OWN HOME					
13a. STATE MD		13b. COUNTY HOWARD		13c. CITY OR TOWN COLUMBIA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6980 DEEP CUP ROAD 21045					
14. FATHER'S NAME FIRST CHARLES		MIDDLE B.	LAST OLD	15. MOTHER'S MAIDEN NAME FIRST ELIZABETH		MIDDLE R.	LAST BEALL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-66-3838			17. INFORMANT HOWARD CALIFANO JR.		ADDRESS COLUMBIA, MD 6980 DEEP CUP ROAD 21045						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTIC SHOCK APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA DAYS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF BREAST 1 YEAR													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a PANCYTOPENIA													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) <input type="checkbox"/> attended the deceased from 11/22/87 , 19_____ to 11/23/87 , 19_____, that (I) <input type="checkbox"/> last saw the deceased alive on 11/23/87 , 19_____, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> did <input type="checkbox"/> view the body after death.													
22b. SIGNATURE <i>T.A. Califano Jr.</i>		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 11/23/87						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) T.A. DADISMAN JR MD		22f. ADDRESS 2 KNOB NORTH DR. COLUMBIA MD 21045											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11/25/87		23c. NAME OF CEMETERY OR CREMATORIAL CRESTLAWN			23d. LOCATION MARRIOTTSVILLE		23e. COUNTY MARYLAND				
24. FUNERAL DIRECTOR LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVE CATONSVILLE, MD 21228		25a. DATE REC'D. BY REGISTRAR NOV 30 1987			25b. REGISTRAR'S SIGNATURE <i>Julie Deacon Radke</i>								

11-31-1967

11-31-1967

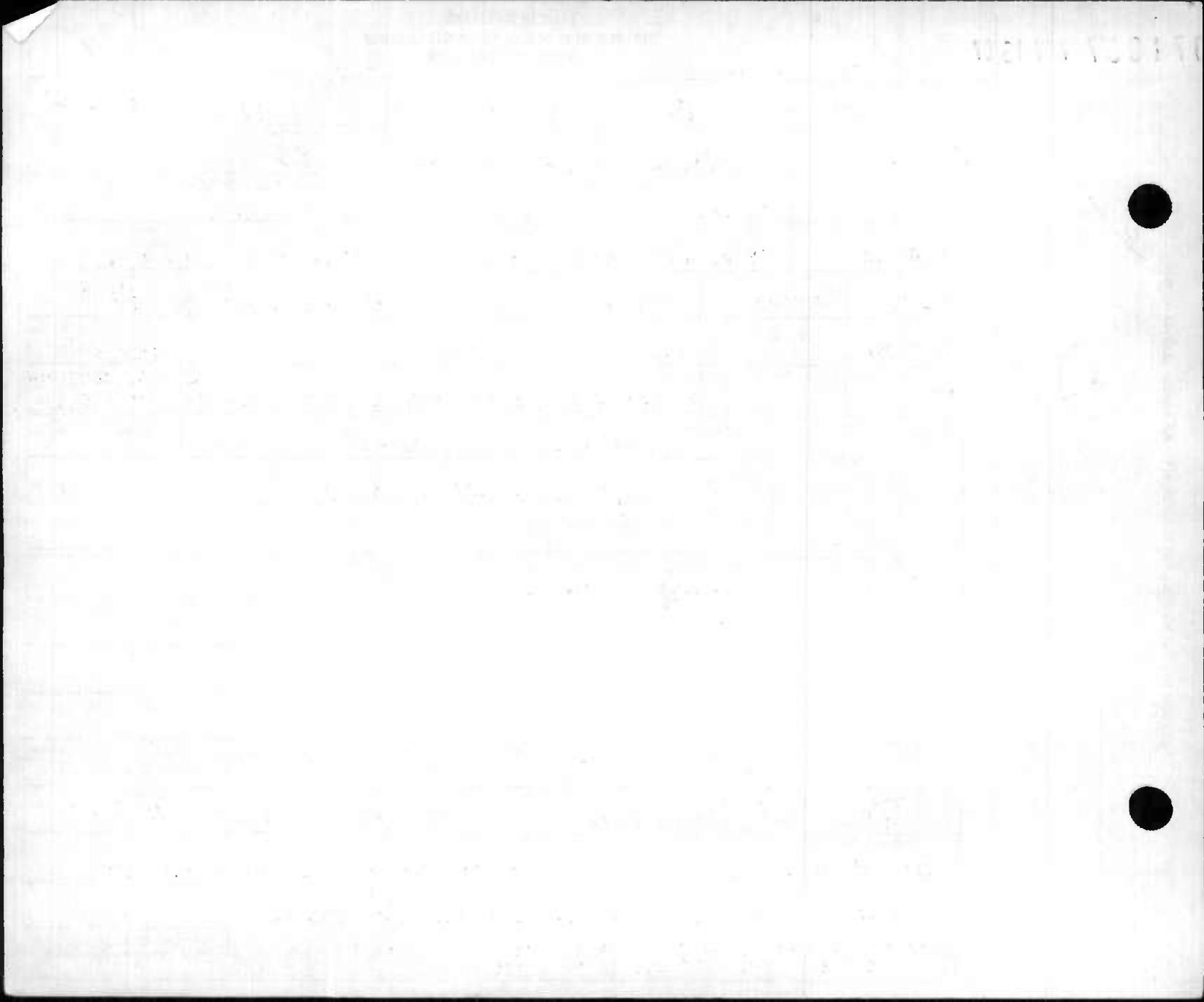
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

within 24 hours after death. Page 4 may be filed by the funeral director. page 3

should be detached for use as the burial/transit permit. Then please remove carbon paper from the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				87	35937	REG. NO.		
1 DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR 9:22 AM
MIRIAM E. CHAMBERS	Miriam	E.	Chambers	11	09	87		
3. SEX Female	4 RACE White	5 DATE OF BIRTH MONTH 12 DAY 24 YEAR 01	6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED XX DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD					
10 CITY OR TOWN OF DEATH COLUMBIA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD COUNTY GENERAL HOSPITAL			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER		12b KIND OF BUSINESS OR INDUSTRY OWN HOME		
13a STATE MARYLAND	13b COUNTY HOWARD	13c CITY OR TOWN COLUMBIA	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO XX	13e STREET ADDRESS / ZIP CODE 10528 D2 CROSS FOX LANE 21044				
14 FATHER'S NAME FIRST CLIFFORD	MIDDLE	LAST EVANS	15 MOTHER'S MAIDEN NAME FIRST ROSA	MIDDLE		LAST RANDOLPH		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b SOCIAL SECURITY NO. 264-80-1229	17 INFORMANT THOMAS CHAMBERS	ADDRESS COLUMBIA, MARYLAND 5065 COLUMBIA ROAD 21044					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Renal insufficiency, anemia								
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	CITY OR TOWN	COUNTY	STATE			
22a I certify that (I) (this hospital) attended the deceased from 10/26 1987 to 11/9 1987 , that (I) (we) last saw the deceased alive on 11/9 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did) not view the body after death.								
22b SIGNATURE Dan P. Moore MD	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 11-9-87					
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. P. Moore	22e ADDRESS 2 KNOLL NORTH DRIVE COLUMBIA, MD 21045							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE 11/11/87	23c NAME OF CEMETERY OR CREMATORIAL LEBANON CEMETERY	23d LOCATION CITY OR TOWN LEBANON	COUNTY	STATE	OHIO		
24 FUNERAL DIRECTOR LEROY M & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVE. CATONSVILLE MD 21228	25a DATE REC'D. BY REGISTRAR NOV 13 1987	25b REGISTRAR'S SIGNATURE Julia Dawson-Landau						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please 4 may be responded by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

WARNING: If item 21 is marked or item 18 shows any injury, an other traumatic event, the medical examiner must be advised.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
REG. NO. 35938												
1 - STATE REGISTRAR			2a. FIRST HERBERT F.			LAST COFFIN			2b. DATE OF DEATH 11/22/87		2b. HOUR 7:30 AM	
1. DECEASED NAME (TYPE OR PRINT)												
3. SEX M			4. RACE W			5. DATE OF BIRTH MONTH 4 DAY 25 YEAR 01			6. AGE 80 IN YEARS LAST BIRTHDAY		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE COUNTRY MINNESOTA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD MD.			
10. CITY OR TOWN OF DEATH COLUMBIA			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS HOWARD COUNTY GENERAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NEGATIVE ENGRAVE			12b. KIND OF BUSINESS OR INDUSTRY U.S. ARMY #1715			
13a. STATE MD			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN SILVER SPRING			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 11200 LOCKWOOD DRIVE 20901	
14. FATHER'S NAME FIRST ORLA MIDDLE CHANCE LAST COFFIN						15. MOTHER'S MAIDEN NAME FIRST LILLIAN MIDDLE LAST WASSERZIHIER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES (YES OR UNKNOWN) 1919-1923			16b. SOCIAL SECURITY NO. 579032015			17. INFORMANT ELNORA V. COFFIN/SAME AS 13/WIFE			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DOUE TO, OR AS A CONSEQUENCE OF												
DOUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) N/A												
19a. DATE OF OPERATION N/A			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from September 19, 1987, to November 22, 1987, that (I) (we) last saw the deceased alive on November 19, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE William Flowers MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/22/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Flowers MD			22e. ADDRESS 11055 Little Patuxent PKwy Columbia MD 21044									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE NOV 24, 1987			23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY			23d. LOCATION CITY OR TOWN SILVER SPRING MONTGOMERY MD			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901						25a. DATE REC'D. BY REGISTRAR NOV 25 1987			25b. RECEIVED BY SIGNATURE John Becker-Lindquist			

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1152121 191370
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NOV 28 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

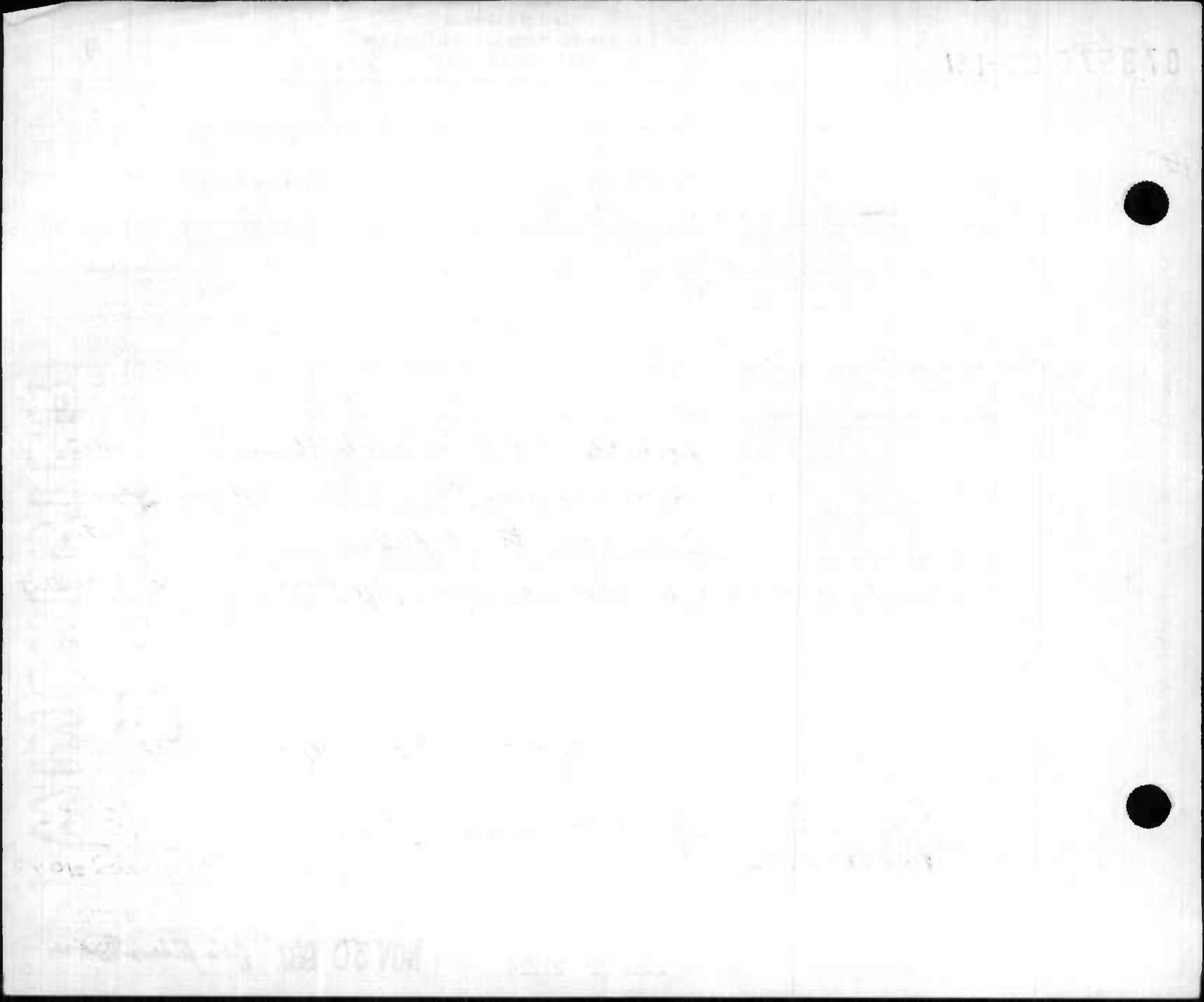
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 (should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal).

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certifying physician must sign this form.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8735939		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
BESSIE M COONEY						11	23	87	8:50 P M			
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR			IF UNDER 24 HRS			
FEMALE	WHITE	MONTH	DAY	YEAR	87 yrs	MONTHS	DAYS	HOURS	MIN.			
80 08 13 1900												
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
MARYLAND	U.S.A.				HOWARD COUNTY MD.							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						
ELLIOTT CITY	BON SECOURS EXTENDED CARE					SECRETARY-CLERK BALTO. CITY						
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE
13a. STATE MARYLAND	13b. COUNTY -----	BALTIMORE	13d. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. 21239 1311 RAMBLEWOOD ROAD APT D								
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S M AIDEN NAME FIRST MIDDLE LAST									
PATRICK W. SCOTT			ELIZABETH			HYLAND						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			
NO			212-40-2466			HELEN ZITZER 1317 DENBRIGHT ROAD CATONSVILLE			MARYLAND 21228			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE 1a) probable cardiac arrhythmia										sudden		
DUE TO, OR AS A CONSEQUENCE OF 1b) Arteriosclerotic cardiovascular disease years												
DUE TO, OR AS A CONSEQUENCE OF 1c) Congestive heart failure months												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>												
22a. I certify that (I) (his hospital) attended the deceased from 9/22/87 to 11/23/87, that (I) (we) last saw the deceased alive on 11/23/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22e. DATE SIGNED 11/24/87		
22b. SIGNATURE R. Kolodrubetz MD										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KOLODRUBETZ										22e. ADDRESS Suite 103 2850 N Ridge Rd Ellicott City Maryland 21043		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN BALTIMORE			
BURIAL			11/25/87			BALTIMORE NATIONAL VETERANS			COUNTY MARYLAND			
24. FUNERAL DIRECTOR LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVE CATONSVILLE MD 21228										25. DATE REC'D. BY REGISTRAR NOV 30 1987 Gina Decker, Registrar		

11-21780



5 6 9 4 0

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**FOR
REGISTRAR**

073983 DEC-3 1875

1. DECEASED NAME (TYPE OR PRINT) CLARENCE H COPELAND

**2a. DATE KNOWN OF ESTI-
DEATH MATED** MONTH DAY YEAR 11 21 1987 0019M

3. SEX M **4. RACE** W **5. DATE OF BIRTH** MONTH DAY YEAR 9 23 09 **6. AGE (IN YEARS
LAST BIRTHDAY)** 98 YRS.

**7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)** NORTH CAROLINA **7b. CITIZEN OF WHAT COUNTRY?** U.S.A.

8. MARRIED NEVER MARRIED
WIDOWED **DIVORCED**

9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD

10. CITY OR TOWN OF DEATH COLUMBIA

**11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)** HIGH 5775 CEDAR HOME 46349 PAINTING CONTR. **12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)** SELF-EMP.

13a. STATE MD **13b. COUNTY** HOWARD **13c. CITY OR TOWN** ERKIDGE **13d. INSIDE CITY LIMITS?** YES NO **13e. STREET ADDRESS** 4523 TURTLE LAKE 21227

14. FATHER'S NAME FIRST MIDDLE LAST JAMES EDWIN COPELAND **15. MOTHER'S MAIDEN NAME** MARTHA ANN BUCKLEY

**16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)** YES **16b. SOCIAL SECURITY NO.** 579-86-537 **17. INFORMANT** ANNE SMITH **ADDRESS** 9024 OLD BRANCH AVE.
CLINTON, MD, 20735

**18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:**

IMMEDIATE CAUSE (a) Cardiac arrhythmia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost.

(b) Coronary Artery disease
DUE TO, OR AS A CONSEQUENCE OF
(c)

**18. APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH** Simult.

19a. DATE OF OPERATION **19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?** **20. AUTOPSY?**
YES NO

**21a. EXTERNAL CAUSE WAS
UNDERLYING OR
CAUSE OF DEATH** **21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19** **21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)**

**21d. INJURY OCCURRED
WHILE NOT WHILE
AT WORK AT WORK** **21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)** **21f. LOCATION
STREET** **CITY OR TOWN** **COUNTY** **STATE**

**22a. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner**

MEDICAL CERTIFICATION

ACTUAL SIGNATURE S. J. Minchew **TITLE (SPECIFY)** Substitute M.D. **DEPUTY MEDICAL EXAMINER** **DATE SIGNED** 11/21/87

**EXAMINER'S NAME
(TYPE OR PRINT)** B. H. Minchew **ADDRESS** 2850 N. Ridge Rd.
Ellicott City, Md. 21043

**23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)** CREMATION **23b. DATE** 23 NOV 87 **23c. NAME OF CEMETERY OR CREMATORIUM** WESTVIEW MEM. PR.

**23d. LOCATION
CITY OR TOWN** CATONSVILLE **23e. COUNTY** BALTO. MD. **23f. STATE**

24. FUNERAL DIRECTOR NAME John D. Slack **ADDRESS** SLACK F.H. ELICOTT CITY MD. 21043 **25a. DATE REC'D. BY REGISTRAR** DEC 03 1987 **25b. REGISTRAR'S SIGNATURE** Julia Jackson-Lindner

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF AN DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PN 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP DHMH - 17 (VR A15 ME (5))

U.S. GOVERNMENT



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THE GOVERNMENT LIBRARIES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial; cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
8735941 REG. NO.											
1 - STATE REGISTRAR	FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
1. DECEASED NAME (TYPE OR PRINT)	Samuel JOSEPH Coran			12	24	87	1205 AM				
3. SEX	4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR IF UNDER 24 HRS			
Male	white	MONTH	DAY	YEAR	8	21	09	78	YRS	MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	7b CITIZEN OF WHAT COUNTRY? U.S.A.			MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH XXXXXX HOWARD COUNTY MD.			
10 CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ATTORNEY			12b KIND OF BUSINESS OR INDUSTRY AT LAW				
12c STATE Maryland	13b COUNTY Howard	13c CITY OR TOWN Columbia	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS / ZIP CODE 5764 Stevens Forest Rd 21045					
14. FATHER'S NAME BENJAMIN MIDDLE COHEN			15. MOTHER'S MAIDEN NAME IDA			16. ADDRESS APT. 618 SHIREEN CORAN 5764 STEVENS FOREST RD. 21045					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? NO			16b SOCIAL SECURITY NO. 114-06-0352			17. INFORMANT					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Congestive cardiomyopathy</u>									< 1 year		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u>									years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Renal failure</u>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b SIGNATURE <u>Stephen A. Cole</u> DEGREE <u>MD</u>											
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS Howard County General Hospital			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22f DATE SIGNED 12/24/87				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 12/24/87		23c NAME OF CEMETERY OR CREMATORIAL ARLINGTON CEMETERY		23d LOCATION CITY OR TOWN BALTIMORE		COUNTY	STATE		
24 FUNERAL DIRECTOR NAME 6010 REISTERSTOWN RD. BALTO., MD 21215		25a DATE REC'D. BY REGISTRAR DEC 30 1987			25b REGISTRAR'S SIGNATURE <u>Sol Levinson & Bros., Inc.</u>						

610-35055

990 02 231

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
87 35694266													
REG. NO.													
1 - FOR STATE REGISTRAR			FIRST			MIDDLE			LAST				
DECEASED NAME (TYPE OR PRINT)			Leo			N			Cosentino				
2. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			2b HOUR			
Male		WHITE		May 19 1915			72 yrs			6 P M			
7a BIRTHPLACE (STATE OR FOREIGN)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH						
MARYLAND		USA					Howard County MD						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
COLUMBIA		Forlen Nutating & Rehabilitative Center 6334 Cedar Lane, Columbia MD 21046					CHAUFFEUR			TAXI			
13a. STATE		13b. COUNTY		14. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Maryland				Baltimore			YES			1311 Linden Avenue, 21227			
15. FATHER'S NAME		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME						
JOSEPPI COSENTINO							GIOVANNA SCUTI						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS						
NO		219-07-4635		FRANCES COSENTINO			1311 LINDEN AVENUE						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>SQUAMOUS CELL LUNG CARCINOMA</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART Ia <u>DIABETES MELLITUS; CHRONIC ORGANIC BRAIN SYNDROME</u>													
19a. DATE OF OPERATION <u>N/A</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT AS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <u>N/A</u>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>N/A</u> 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II) <u>N/A</u>								
21d. INJURY OCCURRED <u>N/A</u>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>N/A</u>			21f. LOCATION STREET <u>N/A</u>		CITY OR TOWN <u>N/A</u>			COUNTY <u>N/A</u>		STATE	
22a. I certify that (1) (this hospital) attended the deceased from above, (1) (we) (did) (did not) view the body after death.		22b. DEGREE			22c. DATE SIGNED <u>12/19/87</u>								
22d. SIGNATURE <u>Ronny L. Reese, MD</u>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Ronny L. Reese, MD</u>		22f. ADDRESS <u>2850 N. RIDGE RD ELLIOTT CITY, MD 21043</u>											
23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>		23b. DATE <u>12/21/87</u>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>LOUDON PARK CEMETERY</u>			23d. LOCATION ADDRESS <u>BALTIMORE CITY MARYLAND</u>						
24. FUNERAL DIRECTOR NAME <u>AMBROSE FUNERAL HOME</u>		ADDRESS <u>1328 SULPHUR SPRING ROAD</u>			25a. DATE REC'D. BY REGISTRAR <u>DEC 21 1987</u>		25b. REGISTRAR'S SIGNATURE						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be delivered for use on the burial/transit permit. Then please remove carbon copies. Pages 2 and 3 would be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, Item 21 and item 22 must be completed.

1650000 0002310



The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified at once.

074311 DEC

887 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 35943 REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST JOHN	MIDDLE	LAST COYLE	2a DATE OF DEATH MONTH 12 DAY 5 YEAR 87	2b HOUR 930 PM				
3. SEX MALE		4 RACE White		5 DATE OF BIRTH MONTH 2 DAY 23 YEAR 17		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Howard County, MD.					
10 CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tool Maker		12b KIND OF BUSINESS OR INDUSTRY Automobile					
13a STATE Michigan		13c. COUNTY Genesee		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 1943 Woodslea Drive Apt. 5					
14. FATHER'S NAME FIRST Edward MIDDLE Coyle		15. MOTHER'S MAIDEN NAME FIRST Margaret MIDDLE McGhee									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		16b SOCIAL SECURITY NO. 379-05-9811		17 INFORMANT Mary McCulla		ADDRESS Blanc, Michigan					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				ACUTE PULMONARY EMBOLUS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 HOUR					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		CHRONIC CONGESTIVE HEART FAILURE 3 YRS							
		(c)		DUE TO, OR AS A CONSEQUENCE OF CORONARY ARTERY DISEASE 5 YRS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a ACUTE RENAL FAILURE HEPATIC CIRRHOSIS											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 21)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 871125 CITY OR TOWN 12/14/87 COUNTY 87 STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8/11/87 to 12/14/87, to 12/14/87, that (I) (we) last saw the deceased alive on 12/14/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Scott Maurer		22c. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 21044					
22e. ADDRESS 10772 HICKORY RIDGE RD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-9-87		23c. NAME OF CEMETERY OR CREMATORIAL New Calvary Cemetery		23d. LOCATION CITY OR TOWN 871125 COUNTY Genesee STATE Michigan					
24. FUNERAL DIRECTOR NAME Marzullo Funeral Service		ADDRESS Upperco, MD.		25a. DATE REC'D. BY REGISTRAR 12/14/87		25b. REGISTRAR'S SIGNATURE					

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BP

100-10000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send entire death certificate (pages 1 and 2) to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87	REG. NO. 35944
DEC 29 1987			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
DECEASED NAME (TYPE OR PRINT)			JEAN H.		CRAWFORD	12	25	87		5 ³⁷ PM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE [IN YEARS LAST BIRTHDAY]	IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE	White	January 28, 1907			80	MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE COUNTRY	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD					
Pennsylvania	U.S.A.										
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
COLUMBIA	HOWARD County General Hosp					Housewife					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 7080 Cradlerock Way 21045					
Maryland	Howard	Columbia									
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST				
John C Hostler			Jessie E Shoenfelt								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS					
No	578 28 6641		Mrs Paul Crawford Jr.			Columbia 5665 Thicket La. 21044					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Respiratory arrest										minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DO TO, OR AS A CONSEQUENCE OF 1b) Aspiration pneumonia										24 hrs.	
DO TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
19a. DATE OF OPERATION none			19b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21c. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. LOCATION								
22a. I certify that (I) (this hospital) attended the deceased from 12/25, 1987, to 12/25, 1987, that (I) (we) last saw the deceased alive on 12/25, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Lynn D. Alonso MD			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/25/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LYNN D. ALONSO			22e. ADDRESS TWO EKOLL NORTH PR, COLUMBIA, MD 21044								
23a. BURIAL, CREMATION, REMOVAL [SPECIFY] Burial			23b. DATE Dec 29, 1987			23c. NAME OF CEMETERY OR CREMATORIAL Maryland Memorial Park			23d. LOCATION Laurel		
									CITY OR TOWN	COUNTY	STATE
									Prince George Md.		
24. FUNERAL DIRECTOR HARRY H. WITZKE 4112 OLD COLUMBIA PIKE Ellicott City			25a. ENTERED BY REGISTRAR DEC 28 1987			25b. RECEIVED BY CLERK John J. Anderson					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon paper. Pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT! If item 21 is marked state any injury or other traumatic event.FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 35945
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Sidney MIDDLE Lindsay LAST Davis			2a. DATE OF DEATH MONTH 11 DAY 22 YEAR 87		2b. HOUR 2015	
3. SEX Male MALE			4. RACE Caucasian WHITE			5. DATE OF BIRTH MONTH 09 DAY 12 YEAR 11 09 12 11		6. AGE (IN YEARS LAST BIRTHDAY) 76 yrs	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Ark. Little Rock			7b. CITIZEN OF WHAT COUNTRY? USA			7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD.	
10. CITY OR TOWN OF DEATH Columbia			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hosp			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Shipping	
13a. STATE MD			13b. COUNTY Howard			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10634 Green Mountain Circle 21044	
14. FATHER'S NAME FIRST Sidney MIDDLE L. LAST Davis Sr.			15. MOTHER'S MAIDEN NAME FIRST Lula MIDDLE Mae LAST Hawkins			ADDRESS Same as #13			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. N/A			17. INFORMANT 212-10-5552 Rita J. Davis			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable myocardial infarction									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) Atherosclerotic Coronary Vascular Disease									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Cerebrovascular disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:00 P.M. 11 22 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from 11-22-87 to 11-22-87, that (I) we last saw the deceased alive on 11-22-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John R. Roberts, M.D.		22c. DEGREE		22d. DATE SIGNED 11-22-87					
22e. PHYSICIAN'S NAME (THE DECEASED) John R. Roberts, M.D.		22f. ADDRESS Howard County General Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation.		23b. DATE 11/16/87		23c. NAME OF CEMETERY OR CREMATORIAL Security Process		23d. LOCATION CITY OR TOWN Baltimore		COUNTY Balto., MD, STATE	
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home, Catonsville, MD		25a. DATE REC'D. BY REGISTRAR NOV 17 1987		25b. REGISTRAR'S SIGNATURE John Davidson, R.P.D.					

162 SW 14570

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

J.G.N. 6 9 4 6

FOR STATE REGISTRAR		LAST Dawkins (Brown)										DATE KNOWN OF DEATH ESTI- MATED				MONTH DAY YEAR		1/2 HOUR			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE				IF UNDER 1 YR.		IF UNDER 24 HRS.		<input checked="" type="checkbox"/>		12-25-87							
Althea		T.						MONTHS		DAYS		<input type="checkbox"/>		12-25-		19 87		1:15P M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		<input checked="" type="checkbox"/>		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		Howard County		MD	
female		black		1 23 1949		38 yrs		USA				<input checked="" type="checkbox"/>									
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		Md		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Howard		US I-70, 1/4 mi. east of Morgan Rd.		Unemployed																	
13a. STATE		Md		13c. CITY OR TOWN		Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		21215									
14. FATHER'S NAME		Walter		LAST		Brown		15. MOTHER'S MAIDEN NAME		ADDRESS		2404 Loyola Northway Apt 102									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		No		16b. SOCIAL SECURITY NO.		17. INFORMANT						Arthur Dawkins 2404 Loyola Northway									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neck injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause lost</u> . (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b).																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?															
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR AM MONTH DAY YEAR <u>11:45AM 12-25-87</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>road</u>			21f. LOCATION STREET <u>US I-70, 1/4 mi east of Morgan Rd.</u> , CITY OR TOWN <u>Howard County</u> , COUNTY <u>Maryland</u> , STATE			over												
22a. I certify that <u>lock</u> charge of the remains described above, held on death resulted from <input type="checkbox"/> Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>																		
ACTUAL SIGNATURE <u>John P. Kokes</u>			TITLE (SPECIFY) M.D. <u>Assistant</u>			MEDICAL EXAMINER			DATE SIGNED <u>12-26-87</u>												
EXAMINER'S NAME (TYPE OR PRINT)			Charles P. Kokes, M.D.			ADDRESS <u>111 Penn Street, Baltimore, MD 21201</u>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <u>Burial 12/31/87</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>Garrison Forest Vet</u>			23d. LOCATION CITY OR TOWN <u>Owings Mills</u>			COUNTY <u>Md</u>									
24. FUNERAL DIRECTOR NAME <u>Wm. c. March F/H West</u>			ADDRESS <u>4300 Wabash Avenue</u>			25a. DATE REC'D. BY REGISTRAR <u>DEC 30 1987</u>			25b. REGISTRAR'S SIGNATURE												



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(4)
07398 14 DEC 88
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1A, PAGE 3, WHICH SHOULD BE USED AS A BURIAL TRANSIT PERMIT. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1 - STATE REGISTRAR		REG. NO. 947															
DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE		LAST			2a DATE KNOWN OF ESTI- DEATH MATED							
Stanford		Leary			DEAN					11-28 1957							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.							
Male		Black		7-23-28		59											
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. NEVER MARRIED DIVORCED		10c. DATE MONTH DAY YEAR		2d. HOUR							
Washington D.C.		U.S.A.						11-30 1987		5:30 PM							
10. CITY OR TOWN OF DEATH		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.															
Columbia		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN SUCH A CITY, GIVE STREET ADDRESS) 5793 1/2 Stevens Forest Rd.															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		12b. KIND OF BUSINESS FOR MOST OF WORKING LIFE Govt. Printing Office Govt.							
Md.		Howard		Columbia				5793 1/2 Stevens Forest Rd. 20755									
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		16. ADDRESS 7913 Red Jacket Way Jessup MD 20794							
Samuel Leonard Dean								Althea									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Artherosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c)		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
No		578-36-6076		Emerson Dean													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b.																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>															
ACTUAL SIGNATURE		Thomas F. Berhart, M.D.		TITLE (SPECIFY)		Deputy		MEDICAL EXAMINER		DATE SIGNED		11-30-87					
EXAMINER'S NAME (TYPE OR PRINT)		Thomas F. Berhart, M.D.		ADDRESS		11-30-87		11-30-87									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 4 DEC 87		23c. NAME OF CEMETERY OR CREMATORIAL CRESTLAWN Mem. Gdn.		23d. LOCATION CITY OR TOWN Merrifield, Va.		COUNTY Fairfax		STATE VA							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR DEC 03 1987		25b. REGISTRAR'S SIGNATURE John D. Berhart											
Slack Funeral Home		Ellwood City, MD 20443															

No-attraction

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87	REG. NO. 35948
1. STATE REGISTRAR (TYPE OR PRINT)		MARGARET M. EDWARDS			MIDDLE EAST		2a. DATE OF DEATH MONTH 11 DAY 2 YEAR 87		2b. HOUR 6:30 AM		
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST		5. DATE OF BIRTH MONTH AUGUST DAY 29, 1910 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 77		IF UNDER 1 YEAR MONTHS YRS IF UNDER 24 HRS HOURS MIN.	
3. SEX FEMALE		4. RACE WHITE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY			
10. CITY OR TOWN OF DEATH COLUMBIA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD COUNTY GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOKKEEPER		12b. KIND OF INDUSTRY HOSPITAL -SIERRA COMMUNITY					
13a. STATE MARYLAND		13b. COUNTY HOWARD		13c. CITY OR TOWN COLUMBIA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7167 TALISMAN LANE 21045			
14. FATHER'S NAME FIRST FREDERICK MIDDLE CHRISTOPHER LAST EDWARDS				15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE MARGARET LAST MENNEL							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 099-05-2229		17. INFORMANT KATHY PORTER		ADDRESS 7167 TALISMAN LANE COLUMBIA, MD. 21045					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLUS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PROLONGED ILLNESS / INERTIVITY											
DUE TO, OR AS A CONSEQUENCE OF (c) GASTRIC SURGERY 4 WKS PRIOR											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a ? ASPIRATION											
19a. DATE OF OPERATION 10-8-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED INTRACRIBRAL PEPTIC ULCER				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 21)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10-7-87, 19, to 11-2-87, 19, that (I) (we) last saw the deceased alive on 11-2-87, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE E.C. WITZKE, MD		22c. DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 11-2-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E.C. TORTOLANI		22e. ADDRESS 827 LINCOLN AVE; BALTIMORE									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 11/5/87		23c. NAME OF CEMETERY OR CREMATORIAL WESTVIEW CREMATORY		23d. LOCATION CITY OR TOWN CATONSVILLE		COUNTY STATE MARYLAND			
24. FUNERAL DIRECTOR NAME LEROY M. & RUSSELL C. WITZKE FIRM NAME TWIN KNOLLS RD. COLUMBIA, MD. LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES				25a. DATE RECEIVED BY REGISTRAR NOV 03 1987		25b. REGISTRAR'S SIGNATURE Julie B. D. Redden					

104-101 537050

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 7 3 5 9 4 9

DECESSED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
HARRY R. ELARDO						DECEMBER 15, 1987				7:40A M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MAY 23, 1924		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
						63	YRS.	MONTHS	DAYS	HOURS	MIN.
7a BIRTHPLACE COUNTRY MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY		MD.			
10 CITY OR TOWN OF DEATH COLUMBIA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD COUNTY GENERAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CHEF		12b KIND OF BUSINESS OR INDUSTRY RESTAURANT					
13a STATE MARYLAND		13b COUNTY HOWARD	13c CITY OR TOWN COLUMBIA	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 8740 AIRY BRINK LANE 21045					
14. FATHER'S NAME FIRST ROSARIO		MIDDLE	LAST ELARDO	15. MOTHER'S MAIDEN NAME FIRST LENA		MIDDLE	LAST DICARO				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. WW II		17 INFORMANT MRS. FRANCES ELARDO		ADDRESS SAME AS # 13					
18 CAUSE OF DEATH (Enter only one cause per line for 1a), 1b ¹ , and 1c ² PART I. DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		{ b) <i>Bronchogenic Carcinoma - metastatic</i>						Months			
		DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic anemia</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Chronic anemia</i>											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>87</u> , to <u>Dec 17</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>November</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Jon K. Minford</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 12-16-87					
22d PHYSICIAN'S NAME (TYPE OR PRINT) JON K. MINFORD M.D.		22e ADDRESS 10806 HICKORY RIDGE									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/18/87		23c. NAME OF CEMETERY OR CREMATORIUM LORRAINE PARK		23d LOCATION CITY OR TOWN BALTIMORE		COUNTY	STATE		
24. FUNERAL DIRECTOR LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES P.A. 1630 EDMONDSON AVENUE, CATONSVILLE, MD.				25a. DATE REC'D. BY REGISTRAR 21228 DEC 17 1987		25b. REGISTRAR'S SIGNATURE <i>J. Jon K. Minford</i>					

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FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

35. NO 950

DECEASED NAME (TYPE OR PRINT)				FIRST MARY	MIDDLE E.	LAST EVANS	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 11-21-87	MONTH DAY YEAR 11 21 87	2b. HOUR 1157 A M	
3. SEX F	4 RACE B	5. DATE OF BIRTH MONTH DAY YEAR 5 27 28	6 AGE (IN YEARS LAST BIRTHDAY) YRS. 59	7. IF UNDER 1 YR. MONTHS 0	8. IF UNDER 24 HRS. DAYS 0	9. IF HOURS HOURS 0	10. IF MIN. MIN 0			
11. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		12. CITIZEN OF WHAT COUNTRY? USA		13. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		14. DATE PRONOUNCED DEAD 11-21 1987				
15. CITY OR TOWN OF DEATH COLUMBIA			16. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD COUNTY GENERAL HOSPITAL			17a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed				
18. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md		19. CITY OR TOWN COUNTY Baltimore		20. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21. STREET ADDRESS 13 N. Gilmore St				
22. FATHER'S NAME FIRST Inwood		23. MIDDLE Nash		24. MOTHER'S MAIDEN NAME FIRST Louise		25. LAST Gross				
26. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		27. SOCIAL SECURITY NO. 215-22-5977		28. INFORMANT Renard Nash		29. ADDRESS 401 Penhurst Ave				
30. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Simultaneous										
31. CONDITIONS DUE TO, OR AS A CONSEQUENCE OF IMMEDIATE CAUSE (a) Cardiac arrhythmia DUE TO, OR AS A CONSEQUENCE OF { (b) coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension DUE TO, OR AS A CONSEQUENCE OF years years										
32. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 to										
33. MEDICAL CERTIFICATION		34. DATE OF OPERATION		35. CONDITION FOR WHICH OPERATION WAS PERFORMED?			36. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
37. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		38. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		39. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
40. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		41. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		42. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
43. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									44. TITLE (SPECIFY) Sukha S. Minchew M.D. Deputy MEDICAL EXAMINER	
45. ACTUAL SIGNATURE Sukha S. Minchew									46. DATE SIGNED 11/21/87	
47. EXAMINER'S NAME (TYPE OR PRINT) B.H. Minchew		48. ADDRESS 2850 N. Ridge Rd Ellicott City, Md. 21043								
49. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		50. DATE 11/25/87		51. NAME OF CEMETERY OR CREMATORIAL King Memorial Park			52. LOCATION CITY OR TOWN Randallstown		COUNTY	STATE
53. FUNERAL DIRECTOR NAME Wm. C. March F/H West		54. ADDRESS 4300 Wabash Avenue		55. DATE REC'D. BY REGISTRAR NOV 24 1987			56. REGISTRATION SIGNATURE Jill Jackson			



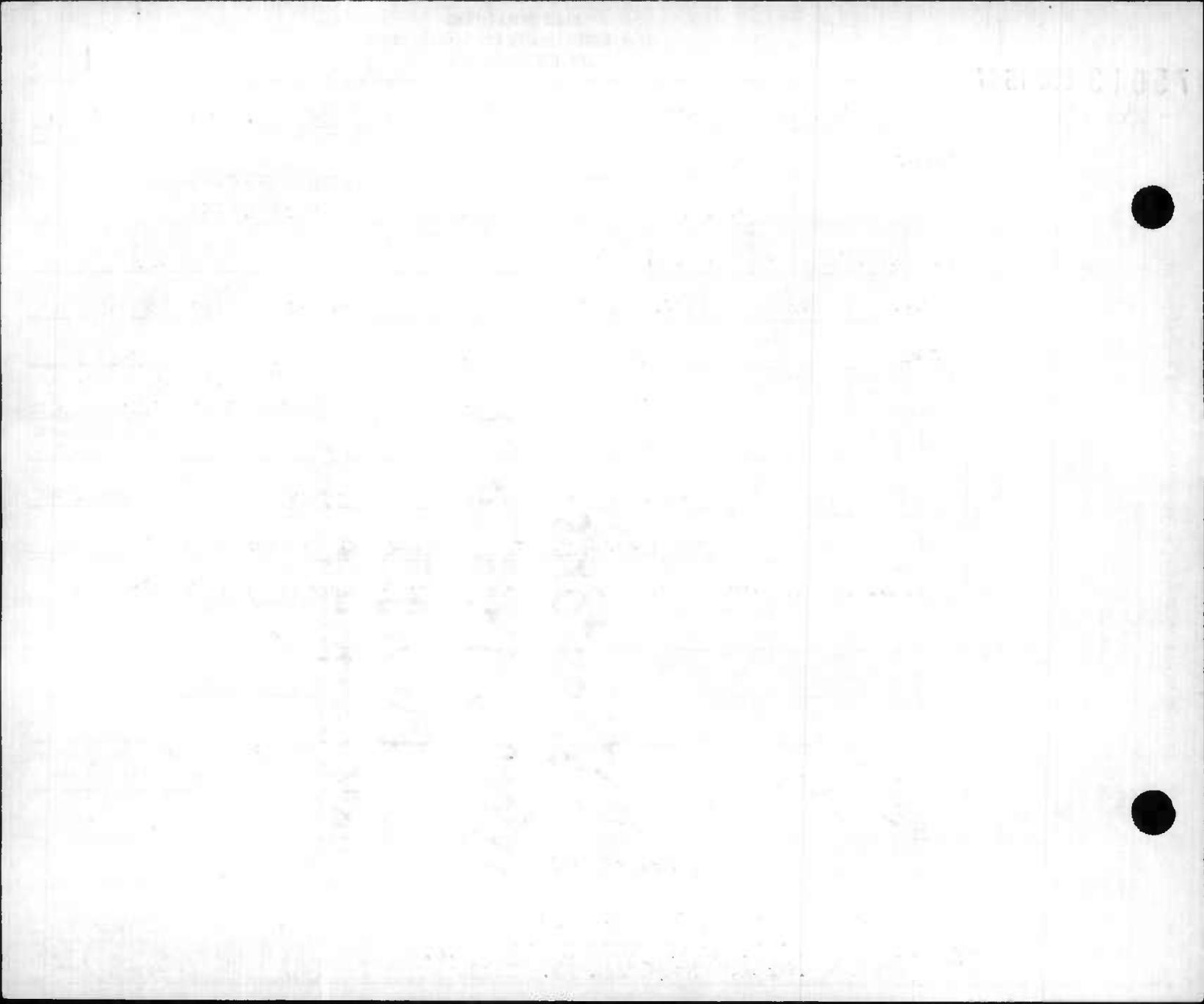
75013 DEC 15 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resubmitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT! If Item 21 is marked or if items 18-20 show any injury, an other traumatic event, the medical certifier must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1 - FOR STATE REGISTRAR			2a DATE OF DEATH			MONTH			DAY		YEAR
DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST								
STEPHANIE ANNE FAGGIO						DECEMBER 7, 1987					
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH 10 06 83			6. AGE (IN YEARS LAST BIRTHDAY) 4 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			7c. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY		
10. CITY OR TOWN OF DEATH ELLIOTT CITY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8469 ROBERTS ROAD						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		
13a. STATE MARYLAND			13b. COUNTY HOWARD			13c. CITY OR TOWN ELLIOTT CITY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST JOHN MIDDLE A. LAST FAGGIO						15. MOTHER'S MAIDEN NAME FIRST LINDA MIDDLE P. LAST FRIEDMAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-11-4976			17. INFORMANT			ADDRESS MARYLAND 21043		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPOXIA									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DOUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY INSUFFICIENCY						1 MONTH		
			DOUE TO, OR AS A CONSEQUENCE OF (c) CONGENITAL FIBER TYPE DISPROPORTION						4 YRS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a UNDIAGNOSED CENTRAL NEUROLOGIC DETERIORATION ; BRONCHITIS											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10-6 1983 to 12-7 1987 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12-5 1987 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> did not view the body after death.											
22b. SIGNATURE <i>Christine L. Compton</i>			22c. DEGREE ms			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 12-7-87		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) CHRISTINE L. COMPTON, MD			22f. ADDRESS 5411 OLD FREDERICK RD #10 CATONSVILLE, MD 21229								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/10/87			23c. NAME OF CEMETERY OR CREMATORIUM CRESTLAWN CEMETERY			23d. LOCATION CITY OR TOWN MARIOTTSVILLE COUNTY STATE MARYLAND		
24. FUNERAL DIRECTOR LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228						25a. DATE REC'D. BY REGISTRAR DEC 14 1987			25b. REGISTRAR'S SIGNATURE <i>Julia Sieden-Randall</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper from item 24 and attach it to the back of this page. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR		
WILLIAM K. FIELDS						11/06/87	11	6	87		
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
WILLIAM K. FIELDS						11/06/87		11	6	87	1:12 A.M.
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	REG. NO. 3 5 9 5 2				
MALE	WHITE		01/22/43			44 YRS					
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
WASHINGTON D.C.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			HOWARD				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									
COLUMBIA		HOWARD COUNTY GENERAL HOSPITAL									
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE				
MARYLAND		HOWARD	COLUMBIA		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	10837 BRAEBURN RD. 21044					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		MIDDLE	LAST			
MESBA		WILLIAM		FIELDS	ELVA		C.	VARNER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
YES		1960-1966		577-54-7110		CHRISTINE FIELDS 10837 BRAEBURN RD. COLUMBIA MARYLAND 21044					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Artery Disease</i>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>None</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (the hospital) attended the deceased from 9/8 1986, to PRESENT, 19_____, that (I) (we) last saw the deceased alive on 8/20 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE <i>Francis Bruno</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-6-87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANCIS BRUNO MD		22e. ADDRESS Columbia, MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 11-9-87		23c. NAME OF CEMETERY OR CREMATORIAL WESTVIEW CREMATORIAL		23d. LOCATION CITY OR TOWN CATONSVILLE BALTIMORE MD COUNTY STATE					
24. FUNERAL DIRECTOR NAME LEROY M & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVE. CATONSVILLE MD 21228		25. REGISTERED BY REGISTRAR SIGNATURE NOV 9 1987, J. L. WITZKE									

NOV 1961 106150

NOV 9 1961

074306 DEC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy paper. Part 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, referred to in Part 2, attach a separate sheet and describe in detail.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
87 REG. NO. 35953															
1 - STATE REGISTRAR			RUTH M. FLOWERS			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
DECEMBER 6 1987						DEC. 6 1987			9:30 PM						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Fe		W		4 21 1900			87			YRS	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
So CAROLINA		USA									HOWARD MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
COLUMBIA		LORIEN NURSING HOME										Housewife			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STREET ADDRESS / ZIP CODE			
13a. STATE Maryland		13b. COUNTY VA		13c. CITY OR TOWN Glen Burnie			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1032 Dunbarton Road 21061					
14. FATHER'S NAME		FIRST Jack		MIDDLE		LAST Hough		15. MOTHER'S MAIDEN NAME			LAST McCrory				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS								
No		--		577-32-7552			Jacqueline Bianco 1032 Dunbarton Rd. 21061								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) probable arrhytmia												rule			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												DUE TO, OR AS CONSEQUENCE OF (b) Arterio sclerotic cardiovascular disease years.			
												DUE TO, OR AS CONSEQUENCE OF (c) Congestive heart failure.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Alzheimer's disease, atrial fibrillation															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
					<input type="checkbox"/> YES <input type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (we) attended the deceased from saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.		11/24 87			12/6 1987			12/6 1987		12/6 1987		12/6 1987			
22b. SIGNATURE R. Kolodnubetz												22c. DATE SIGNED 12/7/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Kolodnubetz		22e. ADDRESS Suite 103, 2850 N. Ridge Rd						ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/9/87			23c. NAME OF CEMETERY OR CREMATORIAL Lakemont Memorial Gdns.			23d. LOCATION CITY OR TOWN Davidsonville		COUNTY Maryland		23e. DATE REC'D. BY REGISTRAR DEC - 7 1987			
24. FUNERAL DIRECTOR NAME A. Alan Seitz, Jr. 3818 Roland Ave. 21211		ADDRESS						25a. REGISTRAR'S SIGNATURE Hall				25b. REGISTRAR'S SIGNATURE Hall			

MB-33 806150

1997-000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death.

REMAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please return carbon copy to the State Dept. of Health and Mental Hygiene prior to burial or transit.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
				87 REG. NO. 35954							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Ruth C. Francen						November		8	1987		5:15 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)					
Female		white		Month Day Year 10 28 91		If Under 1 Year 96 YRS.		# Under 1 Year Months Days		# Under 24 mos. Hours Min	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
New York		U.S.A.				Howard					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Reisterstown MD		Sent Nursing Home				Homemaker				Domestic	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		14. FATHER'S NAME	
Md.		Howard		Elliott City		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		9339 Michael's Way		FIRST MIDDLE LAST	
W.M.		O'Keefe		Cecelia							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS				19. DATE OF OPERATION	
No		148-14-0517		CHARLES FRANCEN		11624 #103 Little Patuxent Pkwy.					
						Columbia, Md. 21044					
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Altersosclerosis (V) Disease						Years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20c. AUTOPSY?		20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 11-7-1987 to 11-8-1987, that (I) (we) lost above, (I) (we) (did) (not) view the body after death.											
22b. SIGNATURE C.E. Williams		DEGREE MD		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED 11-8-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.E. Williams (A.D.)		22e. ADDRESS 11904 Henlester Rd., Reisterston, Md. 21136									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 11 NOV 87		23c. NAME OF CEMETERY OR CREMATORIAL RESTLAND		23d. LOCATION CITY OR TOWN EAST HARROUX		COUNTY		STATE Md.	
BP _____											
DHMH-16 25M (VRA 15, 4) 1/79						25a. DATE REC'D. BY REGISTRAR NOV 12 1987		25b. REGISTRAR'S SIGNATURE			
SLACK FUNERAL Home		ADDRESS ELLIOTT CITY, MD 21042									

7081 W 9401 10

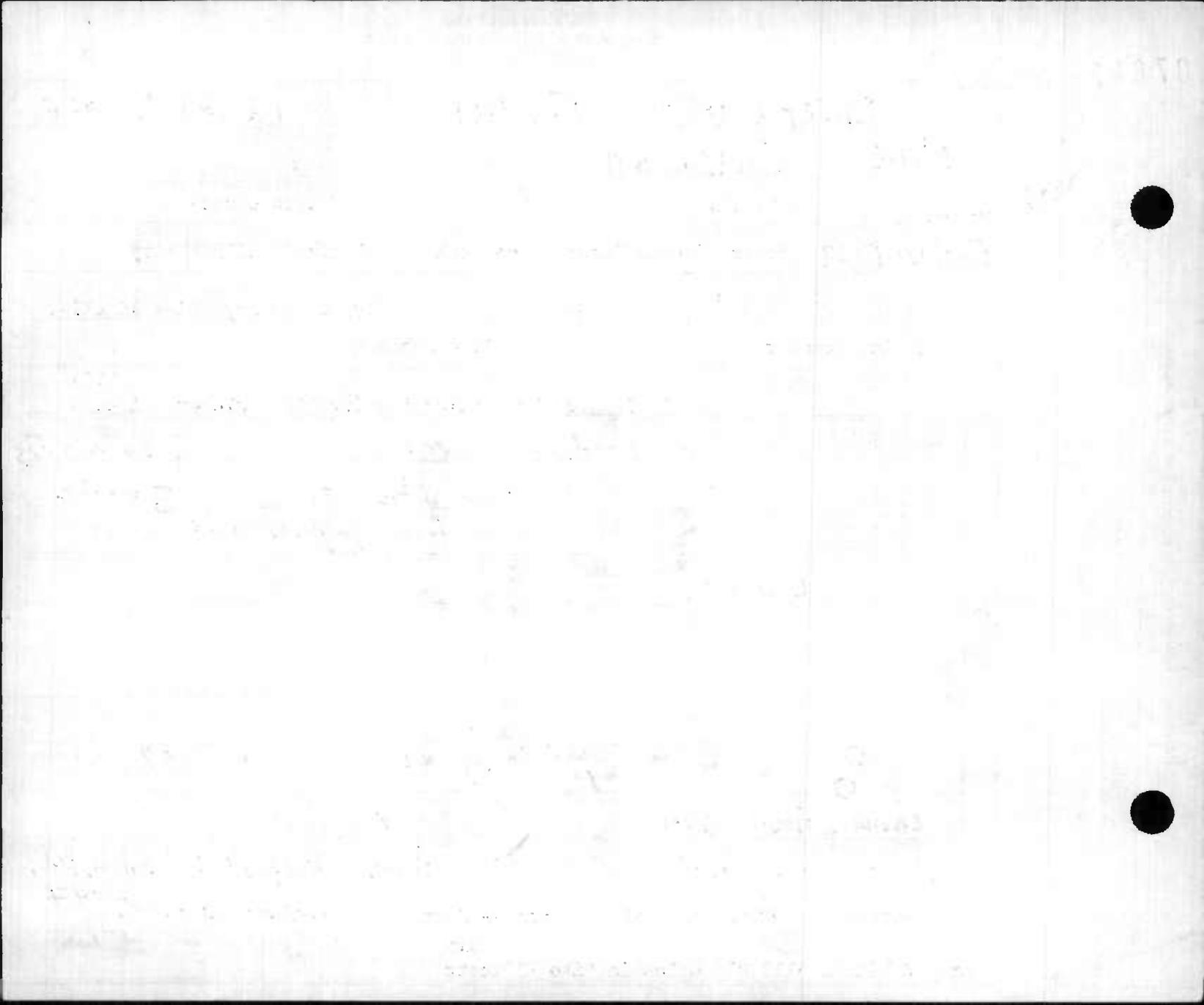
38

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
87 35955 REG. NO.													
1 - STATE REGISTRAR			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
DEC 29 1987			Oliver Curtis Frazier			12 25 87			140 P.M.				
1. SEX		4 RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Male		Caucasian		MONTH 04 DAY 09 YEAR 10			77			IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland		U.S.A.					Howard County						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN MD, INDICATE, GIVE STREET ADDRESS)											
Columbia		Howard County General Hospital											
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
		MD		Howard		Columbia		YES <input type="checkbox"/> NO <input type="checkbox"/>		Retired		Milk Dairy	
14. FATHER'S NAME		William Frazier		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				213 10 4706		Mrs Beulah Frazier		cardiac Arrest		10799 Hickory Ridge Rd		21044 20 minutes	
								(b)					
								DUE TO, OR AS A CONSEQUENCE OF (b)		pneumonitis rt.		3 weeks	
								(c)		Arteriosclerotic cardiovascular disease		years	
19. MEDICAL CERTIFICATION		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a C. O. P. D.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) this hospital attended the deceased from Nov. 30 1987 to Dec. 25 1987, that (I) we last saw the deceased alive on Dec. 25 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) did (did not) view the body after death.													
22b. SIGNATURE Chong Choon Han		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Chong Choon Han		22e. ADDRESS 10792 Hickory Ridge Rd., Columbia, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 29, 1987		23c. NAME OF CEMETERY OR CREMATORIAL Lorraine Park			23d. LOCATION Woodlawn Balto. Md.			21044			
24. FUNERAL DIRECTOR NAME Harry H Witzke		ADDRESS 4112 Old Columbia Pike Ellicott		City			25a. DATE REC'D. BY REGISTRAR DEC 28 1987			25b. REGISTRAR'S SIGNATURE S. J. Frazier			
DHMH - 16 60M 7/B4 (VRA 15, 4)													



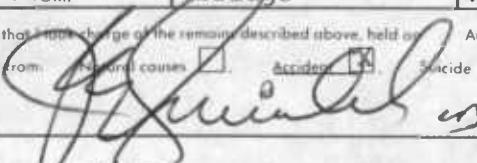
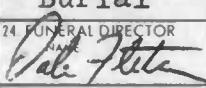
071994 NOV 17 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 35956

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGE 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 201. A FEE OF \$10.00 WILL BE CHARGED FOR EACH FEE-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 3 AND 4 SHOULD BE USED AS A BURIAL-TRANSPORT PERMIT. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, Cremation, or Removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH 11 DAY 11 YEAR 1987 OF ESTI. DEATH MATED <input type="checkbox"/>				2b. HOUR 11 11 1987 M				
THOMAS		Robert	GIBBONS		IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 11 DAY 17 YEAR 1942		6. AGE (IN YEARS LAST BIRTHDAY) 44 RS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Montreal, Canada		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County				2d. HOUR 11 11 1987 2:20 AM			
10. CITY OR TOWN OF DEATH Ellicott City		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Westbound I-70 (bridge)		12a. USUAL OCCUPATION (TYPE OF WORK) Ramp BWT Service				12b. KIND OF BUSINESS Airlines					
13. STATE Maryland		14. COUNTY Carroll		13c. CITY OR TOWN New Windsor		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2225 Bowersox 21776					
14. FATHER'S NAME FIRST Thomas		MIDDLE Gibbons		LAST		15. MOTHER'S MAIDEN NAME FIRST Ann		MIDDLE Elizabeth				LAST Ryan	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1963-1966		16c. WAR OR DATES 212-42-4073		17. INFORMANT P. Rose Gibbons		17. ADDRESS 2225 Boxersox Rd. New Windsor, Md. 21776					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												19. APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:40 AM 11-11-1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject fell from bridge.									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Bridge		21f. LOCATION STREET Westbound I-70		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I am in charge of the remains described above, held on death resulted from <input type="checkbox"/> natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE 		TITLE (SPECIFY) Chief M.D.		MEDICAL EXAMINER									
EXAMINER'S NAME (TYPE OR PRINT) John E. Smialek, M.D.		ADDRESS 111 Penn St., Balto., MD 21201		DATE SIGNED 11-11-87									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-14-87		23c. NAME OF CEMETERY OR CREMATORIAL Meadow Branch		23d. LOCATION CITY OR TOWN Westminster		COUNTY Carroll		STATE Md.			
24. FUNERAL DIRECTOR NAME 		Thomas D. Fletcher & Son F.H.		DATE REC'D. BY REGISTRAR NOV 16 1987		25b. REGISTRAR'S SIGNATURE 							
DAHMH - T7 (VR A15 ME (5))													

SEARCHED 10/17/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

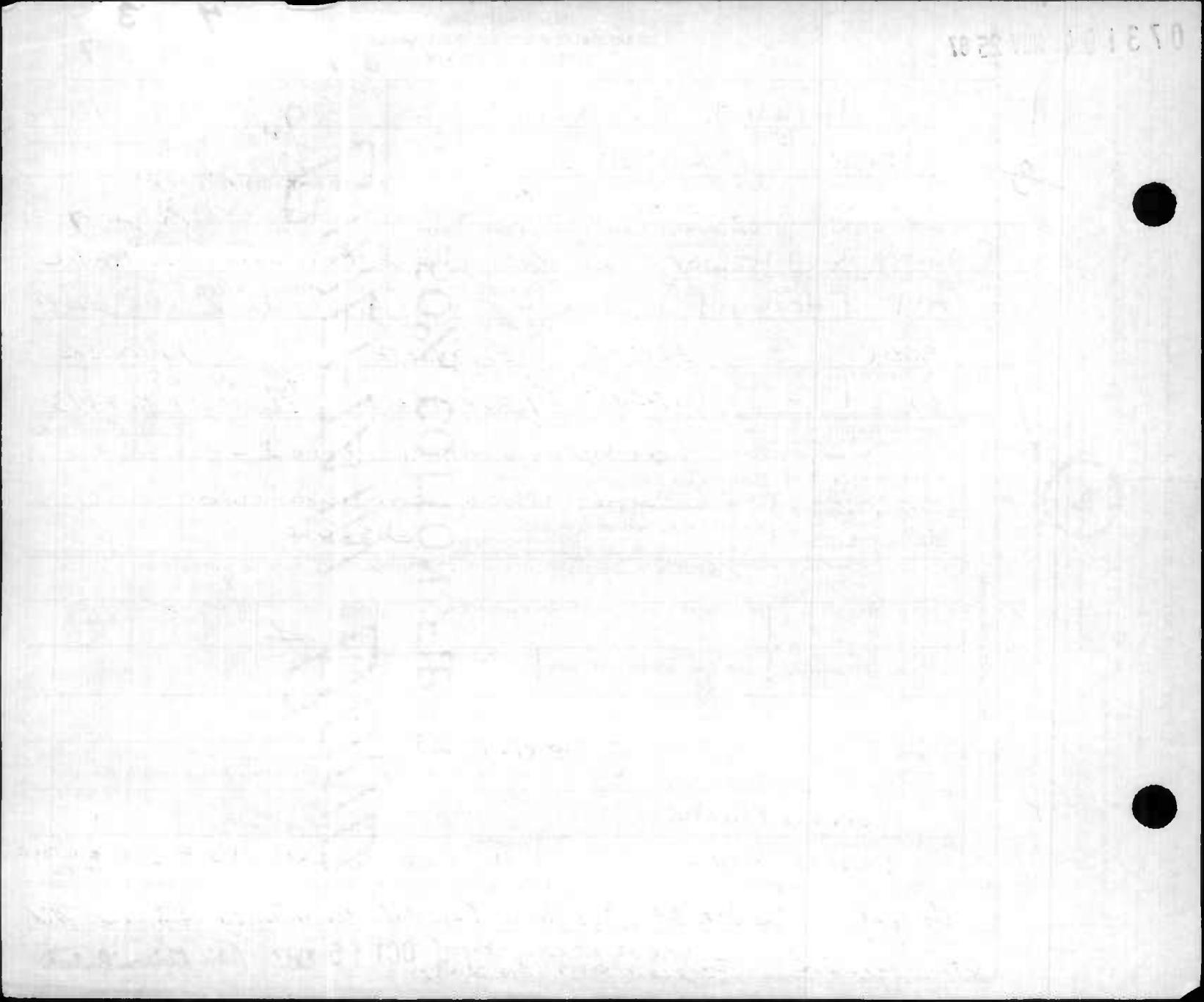
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, attach it by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return entire card in paper pages 1 and 2 should be used within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)				FIRST MARGARET M.	MIDDLE GIMENEZ	LAST	2a. DATE OF DEATH MONTH DAY YEAR	REG. NO. 87 35957	2b. HOUR 1035 PM
3. SEX <input checked="" type="checkbox"/> FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH unknown YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 76 yrs	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN				
7a. BIRTHPLACE STATE OR FOREIGN CITY unknown	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD						
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard Co. General Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker				12b. KIND OF BUSINESS OR INDUSTRY Domestic	
13a. STATE Md.	13b. COUNTY Howard	13c. CITY OR TOWN Columbia	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 9648 Route 108					
14. FATHER'S NAME FIRST FRANK	MIDDLE	LAST ECKLES	15. MOTHER'S MAIDEN NAME ELIZABETH	16. ADDRESS 9648 RT 108 ELLIOT CITY, MD 21043				LAST BRIDNER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. - - - 219-54-2945	17. INFORMANT PEDRO D. GIMENEZ					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory Arrest -</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertensive cardiovascular disease</i>					
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 10/18/87 - 19, to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death						22b. DATE SIGNED			
22b. SIGNATURE <i>Levan Ruck</i>						DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEVAN RUCK				22e. ADDRESS HOWARD CO. GEN. HOSP. - COLUMBIA MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 13 Oct. 87	23c. NAME OF CEMETERY OR CREMATORIAL Arlawn Mem. St.	23d. LOCATION CITY OR TOWN Theronsville	23e. COUNTY Howard	23f. STATE Md.				
24. FUNERAL DIRECTOR NAME <i>John D. Ruck</i>	25a. DATE REC'D. BY REGISTRAR OCT 15 1987			25b. REGISTRAR'S SIGNATURE <i>Julia Jordan-Pandrea</i>					

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STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8735958

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
SOPHY					GLASER	November 21, 1987				8:30a m	
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		WHITE	MONT. DAY YEAR April 11, 1899			88 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD					
10. CITY OR TOWN OF DEATH COLUMBIA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6336 Cedar Lane Apt. 341			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME				
13a. STATE MARYLAND		13b. COUNTY HOWARD	13c. CITY OR TOWN COLUMBIA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6336 Cedar Lane Apt. 341 21044				
14. FATHER'S NAME UNKNOWN		MIDDLE	SCHIFF	LAST	15. MOTHER'S MAIDEN NAME TESSA		MIDDLE	LAST	UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. NO 097-09-8836		17. INFORMANT PHYLLIS BROWN - 5511 Hillfall Ct. Columbia		ADDRESS 21045 MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		Acute myocardial infarction									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
{ DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic cardiovascular disease											
{ DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
22a. I certify that (I) (this hospital) attended the deceased from January 19 87 to November 20 19 87, that (I) (we) last saw the deceased alive on October 15 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>William Flowers M.D.</i>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 11/21/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William Flowers M.D.		22e. ADDRESS 11055 Little Patuxent Pkwy. Columbia MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-23-1987		23c. NAME OF CEMETERY OR CREMATORIAL United Hebrew Cemetery		23d. LOCATION Staten Island		COUNTY New York			
24. FUNERAL DIRECTOR & RUSSELL C. WITZKE FUNERAL HOMES P.A. 555 Twin Knolls Rd. Columbia MD. 21045		25a. DATE REC'D. BY REGISTRAR NOV 24 1987		25b. REGISTRAR'S SIGNATURE <i>Landon Lendell</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be attached.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial permit. The place where carbon copies of Part 1 and 2 should be held within 24 hours after death, with the State Dept. of Health and Mental Hygiene prior to removal.

(IMPORTANT: If item 21a is marked on Item 18 shows any injury or some traumatic event, it should be mentioned on Part 1)

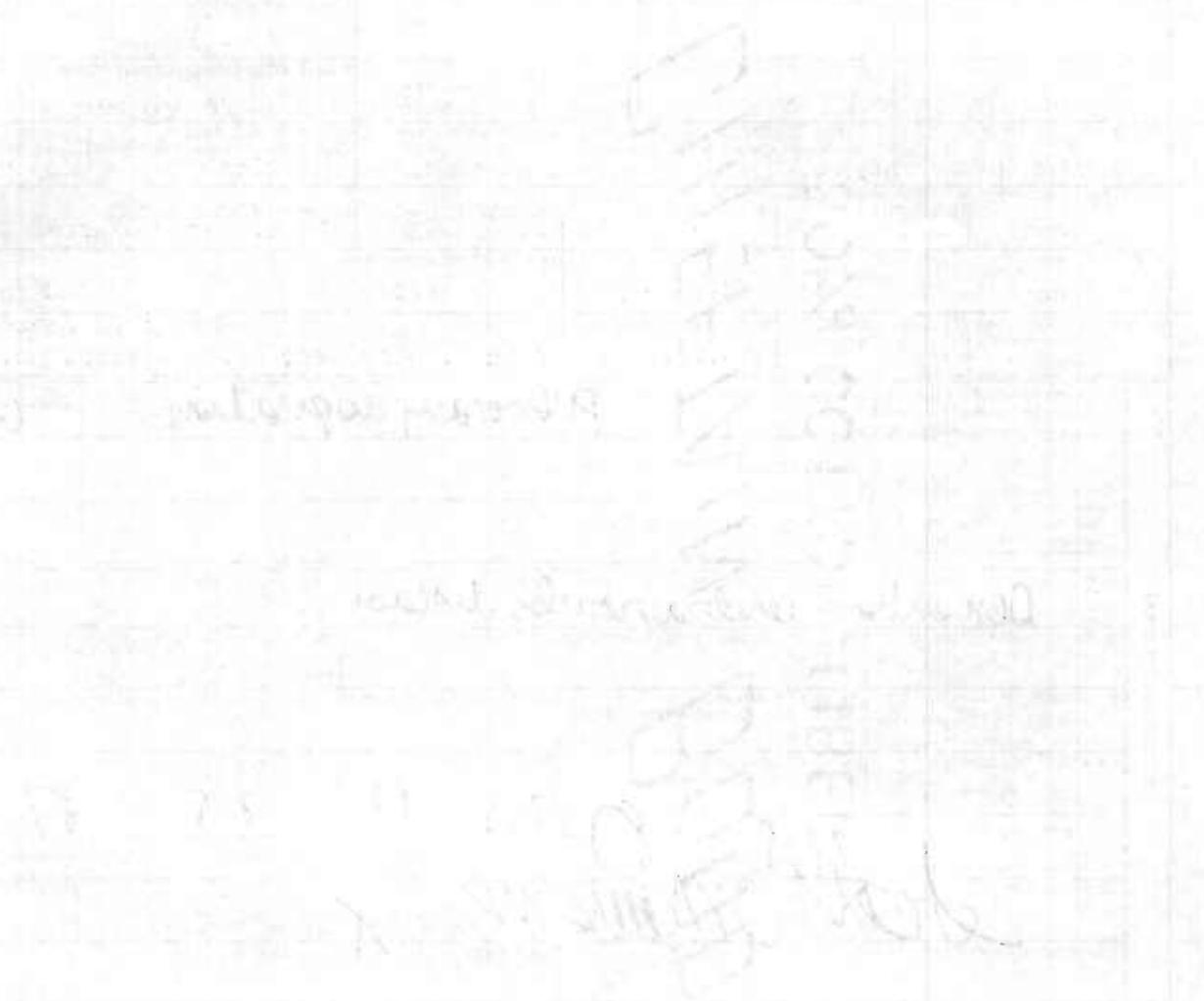
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8735959				
1 - FOR STATE REGISTRAR			1a. DECEASED NAME (TYPE OR PRINT) John Leland Glossner, Sr.			1b. SEX Male			1c. RACE White			1d. DATE OF DEATH December 5, 1987			1e. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	
															1f. MONTH UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
															1g. HOUR 10 A.M.	
1h. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			1b. CITIZEN OF WHAT COUNTRY? USA			1i. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			1j. BALTIMORE CITY OR COUNTY OF DEATH Howard County							
1k. CITY OR TOWN OF DEATH Columbia			1l. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital			1m. USUAL OCCUPATION Clerical			1n. KIND OF BUSINESS OR INDUSTRY Koppers Co.							
1o. STATE Maryland			1b. COUNTY Anne Arundel			13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13c. STREET ADDRESS / ZIP CODE 104 E. North Charter Road 21061							
14. FATHER'S NAME FIRST John MIDDLE E. LAST Glossner			15. MOTHER'S MAIDEN NAME FIRST Effie MIDDLE Carneal LAST													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. NA			17. INFORMANT John L. Glossner, Jr.			ADDRESS 1074 Reece Road Severn, Md. 21144							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 912						Pulmonary aspiration			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)													
			DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
21a. DATE OF OPERATION:			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTE MEDICAL EXAMINER)			21f. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21g. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 21f OR PART 2										
21h. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21i. PLACE OF INJURY AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.			21j. LOCATION STREET CITY OR TOWN COUNTY STATE										
21k. I certify that (I) (this hospital) attended the deceased from 12/15/87 to 12/15/87, that (I) (we) last saw the deceased alive on 12/15/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																
21l. SIGNATURE			21m. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			21n. DATE SIGNED							
21o. PHYSICIAN'S NAME (TYPE OR PRINT)			21p. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec 8, 1987			23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Mem. Park			23d. LOCATION CITY OR TOWN Glen Burnie, A A co. Md. COUNTY STATE							
24. FUNERAL DIRECTOR NAME Singleton Funeral Home			ADDRESS Glen Burnie, Maryland			25a. DATE REC'D. BY REGISTRAR DEC - 8 1987			25b. REGISTRAR'S SIGNATURE J. J. Gordon-Randall							

700-030

4405

00-338 812450



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full in the funeral director's page 3, should be detached for use as the burial/transit permit. Then please remove carbon papers. Paper 3 would be used within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
8735960 REG. NO.												
1 - FOR STATE REGISTRAR			FIRSt			LAST			2a DATE OF DEATH MONTH DAY YEAR			
✓ DECEASED NAME (TYPE OR PRINT)			FEREYDOON			HADI			11 30 87			
3. SEX MALE			4 RACE WHITE			5. DATE OF BIRTH MONTH 08 DAY 23 YEAR 45			6. AGE (IN YEARS LAST BIRTHDAY) 42			
7a BIRTHPLACE COUNTRY IRAN			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.			
10 CITY OR TOWN OF DEATH ELLIOTT CITY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4209 SCARLET SAGE COURT			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOCTOR			12b KIND OF BUSINESS OR INDUSTRY MEDICAL			
13a STATE MARYLAND			13b COUNTY HOWARD			13c CITY OR TOWN ELLIOTT			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST ABDULLAH			MIDDLE HADY			15. MOTHER'S MAIDEN NAME FIRST AKRAM			MIDDLE JAHANSHAH			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO. NO 177-50-9258			17 INFORMANT PATRICIA HADI			ADDRESS ELLIOTT CITY MD 4209 SCARLET SAGE CT 21043			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myotrophic lateral sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED							20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN		COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>9/10</u> , 19 <u>86</u> , to <u>11/16</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>4/16</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (not) view the body after death.												
22b. SIGNATURE <u>Alan Pestone</u>		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11/30/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Alan Pestone</u>		22e. ADDRESS JOHNS HOPKINS HOSP										
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b DATE 12/01/87			23c NAME OF CEMETERY OR CREMATORIAL WESTVIEW CREMATORY			23d LOCATION CITY OR TOWN WESTVIEW		STATE BALTIMORE MARYLAND		
24 FUNERAL DIRECTOR LEROY M. RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVE CATONSVILLE MD 21228					25a DATE REC'D. BY REGISTRAR DEC - 4 1987			25b REGISTRAR'S SIGNATURE <u>Julia Davidson Pendell</u>				

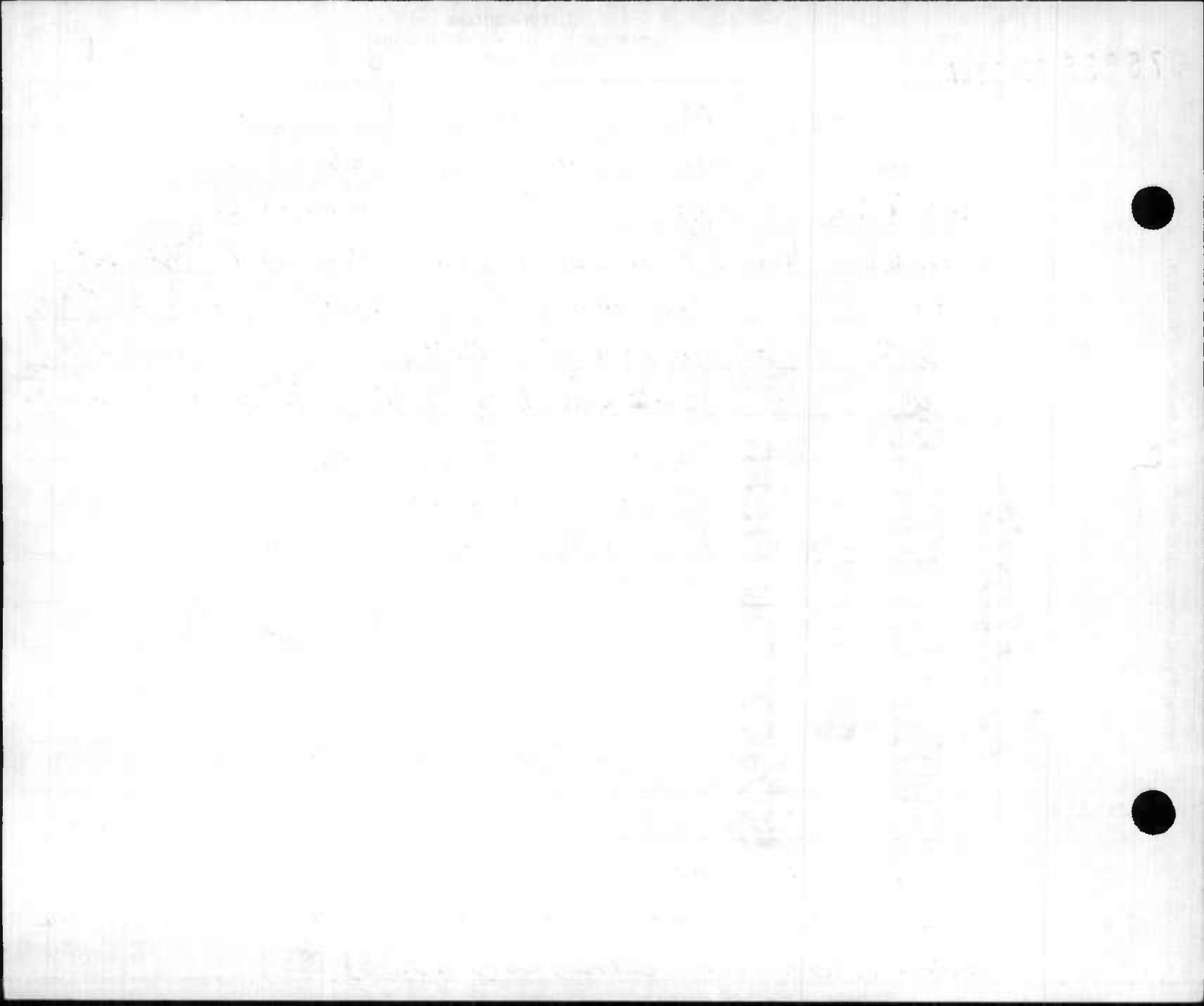
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on item 1, it should be filed in the funeral director's office. Fill in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, we must be notified and a medical certificate will be required.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
87 35961 REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR P			
BILLIE M. HALL						12 - 12-87			8:30 M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS			2b. HOUR P IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
Female		white		09 18 21			66 yrs					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard Co.					
North Carolina		USA										
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard Co. General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Domestic					
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Germantown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS ZIP CODE 19352 Circlegate Dr #201 20874		
14. FATHER'S NAME FIRST MIDDLE LAST Wm A McFarland		15. MOTHER'S MAIDEN NAME Calire										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 238-26-4511		17. INFORMANT Richard A Hall			17. ADDRESS 19352 Circlegate Dr #201 Germantown MD 20874			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory arrest</u>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
{ (b) <u>Acute Pulmonary Edema</u>												
{ DUE TO, OR AS A CONSEQUENCE OF (c) <u>Right lower lobe Pneumonia</u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11-28-87 to 12-12-87, that (I) (we) last saw the deceased alive on 11-12-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Krishna P. Kumar		22c. DATE SIGNED 12-13-87			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KRISHNA P. KUMAR		22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 17 DEC 87		23c. NAME OF CEMETERY OR CREMATORIAL WESTVIEW MEM PK CARRYSBURG			23d. LOCATION CITY OR TOWN STATE PA					
24. FUNERAL DIRECTOR NAME SATIC FUNERAL HOME		ADDRESS ELLCOTT CITY MD		25a. DATE REC'D. BY REGISTRAR DEC 21 1987			25b. REGISTRAR'S SIGNATURE					
DHMH - 16 60M 7/84 (VRA 15, 4)												



077637 JAN

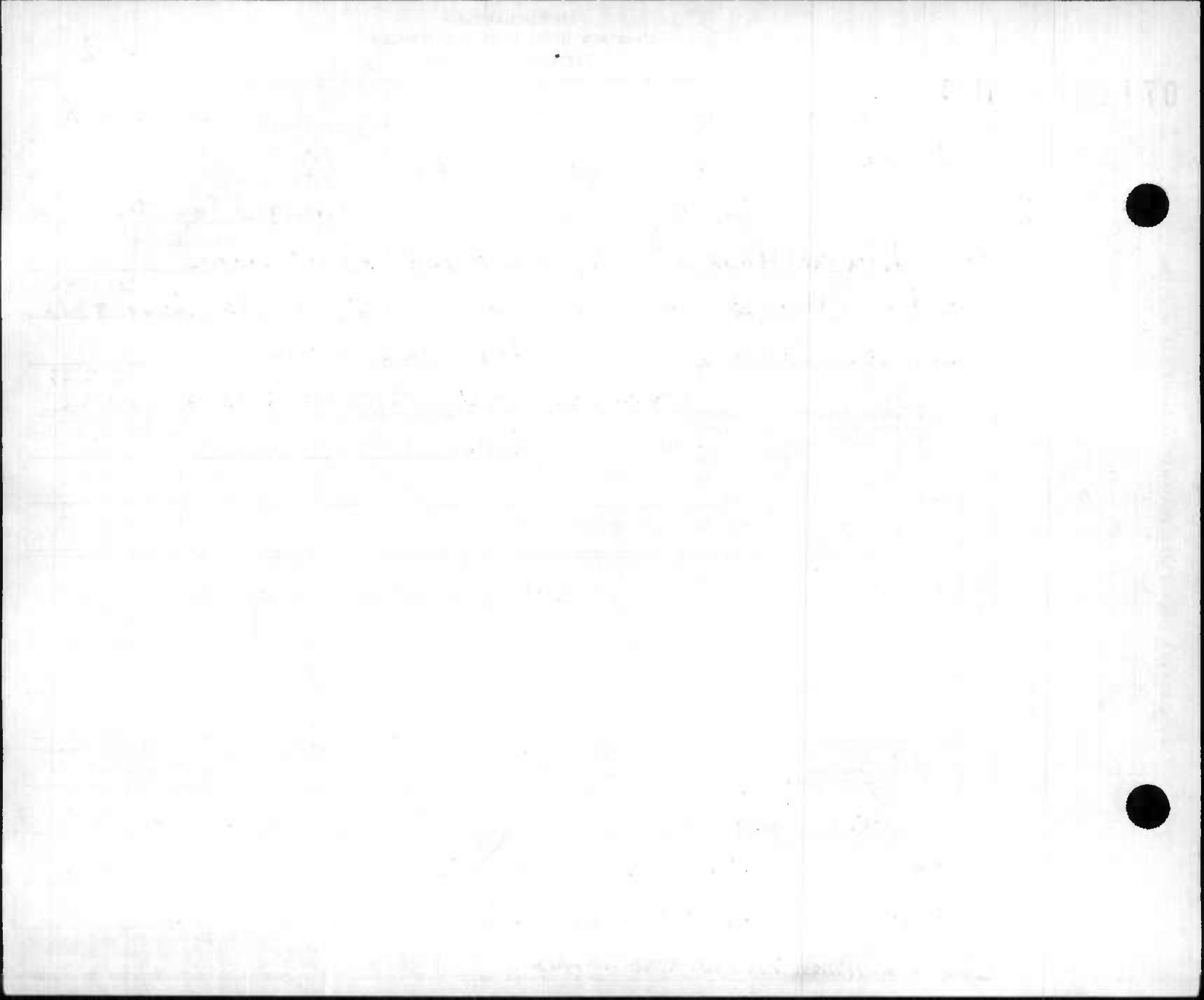
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please move carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
8735962 REG. NO.											
1- STATE REGISTRAR	FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
DECESSED NAME (TYPE OR PRINT)	ELSIE	E.	HALL	Dec 30 1987	840		PM	840 PM			
3. SEX	Female	4. RACE	Black.	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	US	7b. CITIZEN OF WHAT COUNTRY?	US	8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9	79	YRS	BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.		
10 CITY OR TOWN OF DEATH	Columbia Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Howard County General Hospital	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Home maker			12b KIND OF BUSINESS OR INDUSTRY			
13a STATE	Md.	13b COUNTY	Howard	13c CITY OR TOWN	Columbia	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE	21044			
14. FATHER'S NAME	CHARLES	WELDON		15. MOTHER'S MAIDEN NAME	KATHERINE	JOHNSON	ADDRESS	5495 Cedar Lane #212			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	16b. SOCIAL SECURITY NO.	578 01 6357	17 INFORMANT	Mrs. JUNIE STEWART 2940 LAKEWOOD CIR			71321			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>(Congestive heart failure)</i>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week.											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>Diabetes mellitus. Phenylketonuria, probably metformin</i>											
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	CITY OR TOWN		COUNTY		STATE				
22a I certify that (I) (this hospital) attended the deceased from 01-20 1987 to December 30 1987, that (I) (we) last saw the deceased alive on 12/30/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Charles Taylor</i>	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c DATE SIGNED 12-30-87						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Charles E Taylor md</i>	22e ADDRESS 2 Knoll Rock Drive Columbia MD 21045										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE 1-5-88	23c. NAME OF CEMETERY OR CREMATORIAL SERVICES MEM PH	23d. LOCATION CITY OR TOWN BRYAN CO. MD								
24. FUNERAL DIRECTOR NAME <i>JOSEPH L. Russ 2227 W. North Ave</i>	ADDRESS	25a. DATE REC'D. BY REGISTRAR JAN 7 1988		25b. REGISTRAR'S SIGNATURE <i>John D. Johnson</i>							
DHMH - 16 60M 7/84 (VRA 15. 4)											

71 - 2170



enclosed with 24 hours after death. Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN. The

BP _____

DHMH - 16 60M 7
(MPA 15-1)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

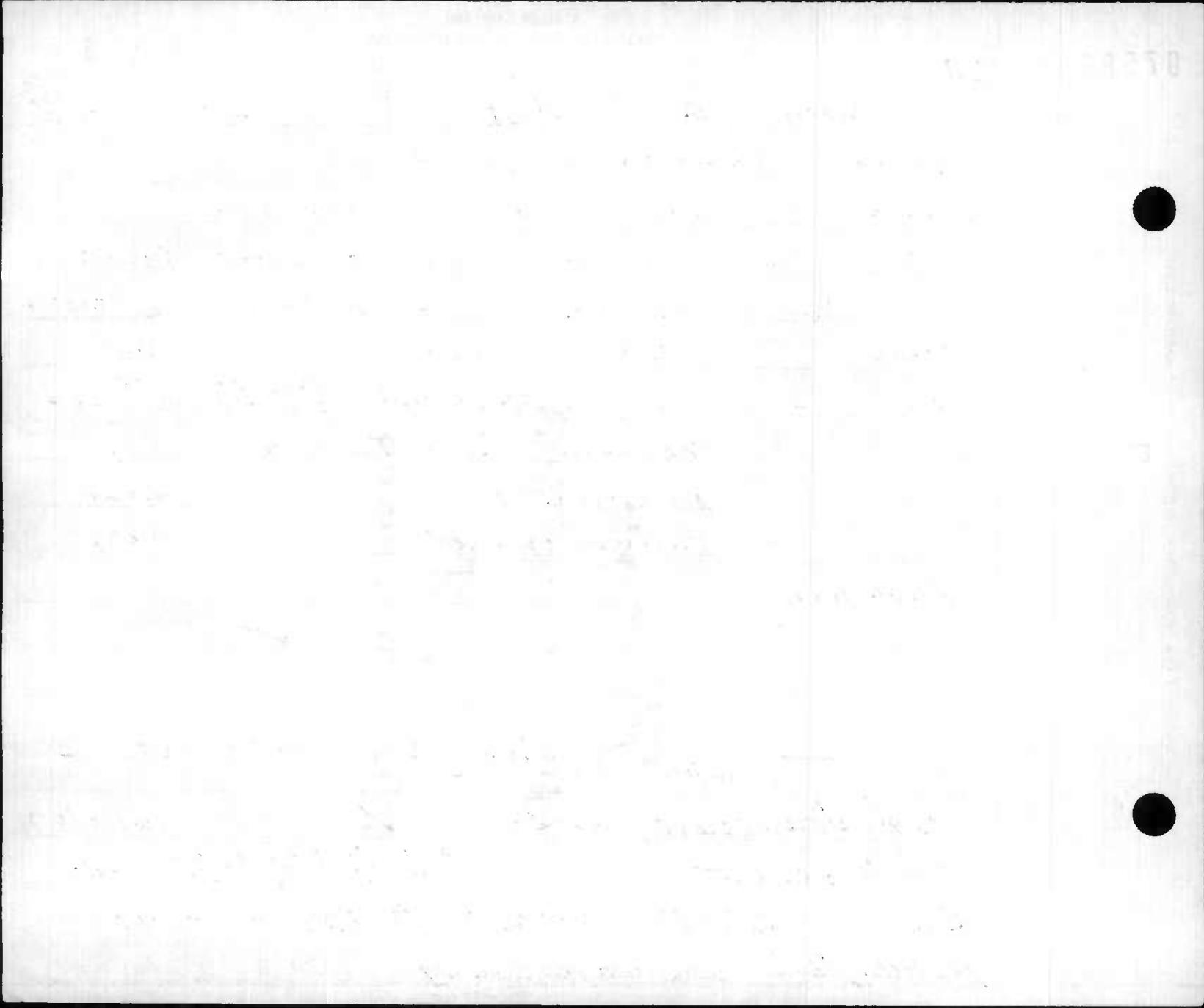
075838 DEC

1- FOR
STATE
REGISTRAR

YGIENE 3 7 3 5 9 6 3
REG. NO.

REG. N

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
Mary M. Hall						12	13	87	11:35 AM					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Female		Caucasian		MONTH	DAY	YEAR	63			IF UNDER 24 HRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Virginia		U.S.A.						Howard Co., MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Columbia		Howard Co. General Hospital			Homemaker			Domestic						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE						
Md		Howard		Elkridge		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		27 Vert Drive 21227						
14. FATHER'S NAME		FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME		ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Isaac				Hall		Molly		6632 Athol Ave. ELKRIDGE, MD 21227			1:45P.M.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)										16b. SOCIAL SECURITY NO.				
No										212-24-7820				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										17. INFORMANT				
Congestive Heart Failure										Glenna Hall				
DUE TO, OR AS A CONSEQUENCE OF (b) Malnutrition										ADDRESS				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										6632 ATHOL AVE. ELKRIDGE, MD 21227				
DUE TO, OR AS A CONSEQUENCE OF (c) Cirrhosis of liver										MOS.				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										MOS.				
Alcoholism														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					<input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (we did) attended the deceased from 11/22, 1987, to 12/13, 1987, that (I we) lost now the deceased alive on 12/13, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (if we did) (did not) view the body after death.														
22b. SIGNATURE B.H. Minchew, M.D.										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B.H. Minchew										22e. ADDRESS 2850 N. Ridge Rd. Ellicott City, Md. 21043				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. DATE REC'D. BY REGISTRAR			23f. REGISTRAR'S SIGNATURE		
Burial		16 DEC 87		MEADOWRIDGE MEM. PK.			Elkridge Howard MD.		DEC 21 1987					
24. FUNERAL DIRECTOR NAME John D. Black										ADDRESS SLACK FUNERAL HOME, ELICOTT CITY				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
87 35964 REG. NO.												
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d HOUR
JAMES EDWARD HAND JR.						11			20	87	1140 PM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS
MALE		WHITE		MONTH	DAY	YEAR	72 YRS			MONTHS	DAYS	HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.		
MARYLAND		U.S.A.					HOWARD COUNTY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
COLUMBIA		5384 SMOOTH MEADOW WAY UNIT 24			OFFICE WORKER			RAILWAY EXPRESS				
13a. STATE MARYLAND		13b. COUNTY HOWARD		13c. CITY OR TOWN COLUMBIA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5384 SMOOTH MEADOW WAY UNIT 24		21044		
14. FATHER'S NAME FIRST JAMES		MIDDLE E.	LAST	15. MOTHER'S MAIDEN NAME FIRST CARRIE		MIDDLE	LAST	RIDLIGEY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <small>(IF YES, GIVE WAR OR DATES)</small> YES		16b. SOCIAL SECURITY NO. WWII		17. INFORMANT MARY HAND		ADDRESS COLUMBIA, MD 21044						
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Sudden Cardiac Death										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) Nonischemic Congestive (Cardiomyopathy)										
		DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 21)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from Nov. 2 1987 to Nov. 7 1987, that (I) (we) last saw the deceased alive on Nov. 7 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Dr. VELTRI		22c. DEGREE MD		22d. ATTENDING PHYSICIAN		22e. MEDICAL DIRECTOR		22f. STAFF PHYSICIAN		22g. DATE SIGNED 11/23/87		
23a. PHYSICIAN'S NAME (TYPE OR PRINT) DR. VELTRI		22g. ADDRESS SINAI HOSPITAL, BALTIMORE MD 21030										
23b. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 11/24/87		23c. NAME OF CEMETERY OR CREMATORIAL LORRAINE PARK CEMETERY			23d. LOCATION WOODLAWN			BALTIMORE MD		
24. FUNERAL DIRECTOR LEROY M & RUSSELL C WITZKE, FUNERAL HOMES 1630 EDMONDSON AVE CATONSVILLE MD 21228		25a. DATE REC'D. BY REGISTRAR NOV 24 1987										
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed while 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please attach copy of papers, Pages 1 and 2, and be filed in the 72 hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be informed.

MEDICAL CERTIFICATION

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Dora L. Harris						Nov	22	87	9:30AM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		Black		Jan 31, 1914		73 yrs		MONTHS DAYS		HOURS MIN.			
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.								Howard MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Columbia		6150 Foreland Garth		Domestic		None							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		21085			
Maryland		Howard		Columbia				6150 Foreland Garth Apt 108					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST				
		Edward		Harris			Mary	E.	Boston				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No				Mrs Phenoris Copes		5202 Bayne Place							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		MATERIALS											
PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
IMMEDIATE CAUSE (a)		SUSPECTED MYOCARDIAL INFARCTION											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE											
		DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from Saw the deceased alive on NOV 2 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (we) (I) (we) (did not) view the body after death.		7 19 86											
22b. SIGNATURE				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/23/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		321 PRINCE GEORGE ST									
ESMAILI H DO		321 PRINCE GEORGE ST											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		11-28-87		Guilford Mem. Cem.		Columbia, Howard, MD							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
George R. Snowden		Rockville, MD 20850		NOV 27 1987		Julia Dinkins-Baker							

W.C.-338 818670

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 showed any injury, or other traumatic event, the medical certification section must be completed.

MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8735966
REG. NO.

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
WILLIAM ELMER HARRIS						11	12	1987		M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE		BLACK		MONTH	DAY	YEAR	76	YRS	MONTHS	DAYS	HOURS	MIN.
12 29 1910												
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY, MD.		10a. OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRUCK DISPATCHER		10b. KIND OF BUSINESS OR INDUSTRY SCHRIEBER truck		
10. CITY OR TOWN OF DEATH COLUMBIA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5237 W. RUNNING BROOK ROAD		12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY COLUMBIA		13c. CITY OR TOWN TOWNSHIP		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME WILLIAM		15. MOTHER'S MAIDEN NAME SARAH		16. SOCIAL SECURITY NO. 190-09-4721		17. INFORMANT Mrs. Jo Anne H. Tyson		13e. STREET ADDRESS, ZIP CODE 5237 W. Running Brook Rd. 21044		13f. COLUMBIA, Md. Apt. 202		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO.		16b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		16c. (IF YES, GIVE WAR OR DATES)		17. CausE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest		17d. (IF YES, GIVE WAR OR DATES)		17e. (IF YES, GIVE WAR OR DATES)		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest		18d. (IF YES, GIVE WAR OR DATES)		18b. DUE TO, OR AS A CONSEQUENCE OF (b) Small Cell CA of lung		18c. DUE TO, OR AS A CONSEQUENCE OF (c)		18d. (IF YES, GIVE WAR OR DATES)		18e. (IF YES, GIVE WAR OR DATES)		
18f. CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Chronic anemia, Diabetes mellitus		18g. (IF YES, GIVE WAR OR DATES)		18h. (IF YES, GIVE WAR OR DATES)		18i. (IF YES, GIVE WAR OR DATES)		18j. (IF YES, GIVE WAR OR DATES)		18k. (IF YES, GIVE WAR OR DATES)		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20c. (IF YES, GIVE WAR OR DATES)		20d. (IF YES, GIVE WAR OR DATES)		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e. LOCATION STREET		21f. CITY OR TOWN		
21g. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21h. LOCATION CITY OR TOWN		21i. COUNTY		21j. STATE		21k. (IF YES, GIVE WAR OR DATES)		21l. (IF YES, GIVE WAR OR DATES)		
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>87</u> , to <u>Nov</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Nov 1987</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.		22b. SIGNATURE <u>Jon K. Minford</u>		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 11-16-87				
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jon K. Minford</u>		22g. ADDRESS 108-6 Hickory Ridge Rd, Columbia MD		22h. (IF YES, GIVE WAR OR DATES)		22i. (IF YES, GIVE WAR OR DATES)		22j. (IF YES, GIVE WAR OR DATES)		22k. (IF YES, GIVE WAR OR DATES)		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11/16/1987		23c. NAME OF CEMETERY OR CREMATORIAL Crest Lawn Cemetery		23d. LOCATION CITY OR TOWN		23e. COUNTY Howard Co., Md.		23f. STATE		
24. FUNERAL DIRECTOR NAME NUNLEY FUNERAL HOMES, INC.		24b. ADDRESS 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216		24c. DATE NOV 19 1987		24d. BY REG. NO. 25b. REGISTRATION NO.		24e. (IF YES, GIVE WAR OR DATES)		24f. (IF YES, GIVE WAR OR DATES)		
BP_____		DHMH - 16 60M 7/B4 (VRA 15, 4)										

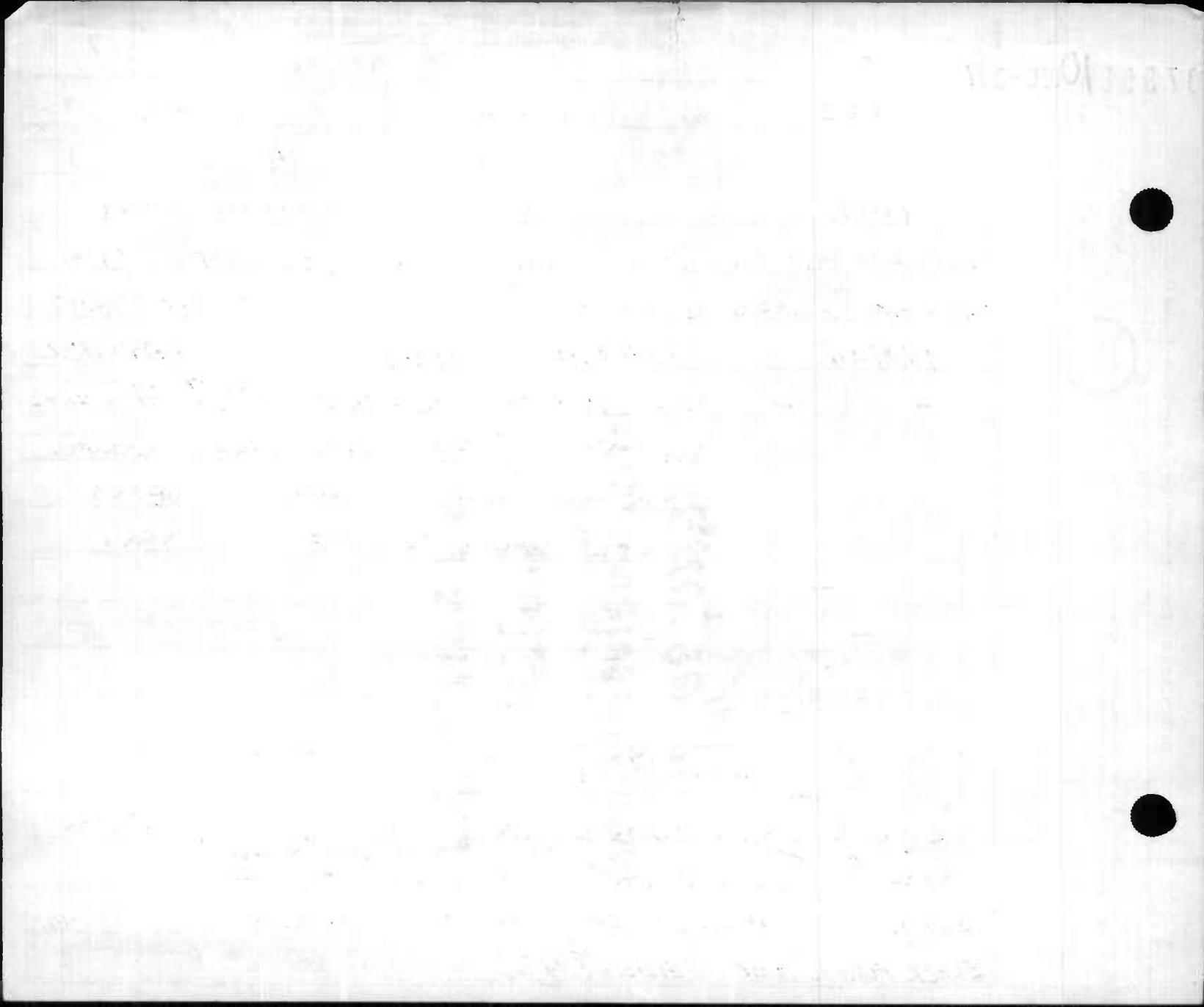
2025 RELEASE UNDER E.O. 14176

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. Then please remove carbon paper. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked with a circled "L", show any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1 - STATE REGISTRAR 87			87			3 5 9 6 7			REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	
LEE			W		HENDERSON	11 24 87			11	24	87	
3. SEX <input checked="" type="checkbox"/>			4. RACE <input checked="" type="checkbox"/>	5. DATE OF BIRTH MONTH DAY YEAR 02 08 13			6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENN.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY			
10. CITY OR TOWN OF DEATH COLUMBIA MD			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD COUNTY FUNERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINIST			12b. KIND OF BUSINESS OR INDUSTRY G.M.			
13a. STATE MARYLAND			13b. COUNTY HOWARD	13c. CITY OR TOWN ELLIOTT CITY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3226 BOONES LANE / 21043		
14. FATHER'S NAME FIRST HAMPTON MIDDLE			15. MOTHER'S MAIDEN NAME LAST HENDERSON FIRST MARY MIDDLE			16. SOCIAL SECURITY NO. 212 01 7958			17. INFORMANT DAVID HENDERSON			ADDRESS 3226 BOONES LN. ELLIOTT CITY 21043
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYOTENSION / CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) ISCHEMIC CARDIOMYOPATHY DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												WEEKS
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2) —						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET —			CITY OR TOWN	COUNTY	STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <input checked="" type="checkbox"/> NOVEMBER 24 1987 to <input checked="" type="checkbox"/> NOV. 24 1987, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <input checked="" type="checkbox"/> NOVEMBER 24 1987, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We did) (did not) view the body after death												
22b. SIGNATURE SUSAN S. HENDERSON, MD			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11/25/87			
22e. ADDRESS 1085 LITTLE PATIENT PKY COLUMBIA, MARYLAND												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 28 NOV 87	23c. NAME OF CEMETERY OR CREMATORIAL BUSH CREEK CEMETORY			23d. LOCATION CITY OR TOWN MONROVIA			COUNTY	STATE MD.	
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME			ADDRESS BOX 268 ELLIOTT CITY, MD			25a. DATE REC'D. BY REGISTRAR DEC 03 1987			25b. REGISTRAR'S SIGNATURE Julia Henderson-Lindner			



The law requires that the death certificate be issued within 4 hours after death. Page 4 may be attached to Hospital or Attending Physician.

ETO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be obtained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

ETO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 2 is marked or Item 19 shows any injury or other traumatic event, the medical examiner must be informed at once.

BP _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 3 5 9 6 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Minnie R Henry						12-1-87				0855 AM			
3. SEX	4. RACE	S. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS				
F	B	9 21 26	61	YRS.	MONTHS	DAYS	HOURS	MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
South Carolina	USA	9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD.											
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Columbia	Howard City General									Housewife			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE							
MD	Howard	Columbia	YES <input type="checkbox"/>	NO <input type="checkbox"/>		21045 5664 Stevens Forest Rd.							
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST				
THOMAS REYNOLDS				WILLIE			BELLE		ADAMSON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS							
NO	578-34-1758		Wallace H. Henry			5664 Stevens Forest Rd. Columbia, Maryland							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Month</i>		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Vertebral Embolism</i>											<i>Month</i>		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary artery disease</i>											<i>Year</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Diabetic mellitus</i>													
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
							YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>11/30</u> , 19 <u>87</u> , to <u>12/1</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/30</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											22c. DATE SIGNED <u>12/1/87</u>		
22b. SIGNATURE <i>Jean Bonton, MD</i>													
22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)											22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY STATE				
Burial		12-4-87		Harmony Memorial Park			Landover, Maryland						
24. FUNERAL DIRECTOR NAME <i>John T. Rhines Co.</i>											25a. ADDRESS <i>3015 12th Street, N.E. Wash</i>	25b. DATE REC'D. BY REGISTRAR <i>DEC - 4 1987</i>	25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>

105-03 708450

105-030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. Fill in by the funeral director. Page 3 should be detached for use as the burial/tranquill permit. Then please remove carbon paper, sign and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

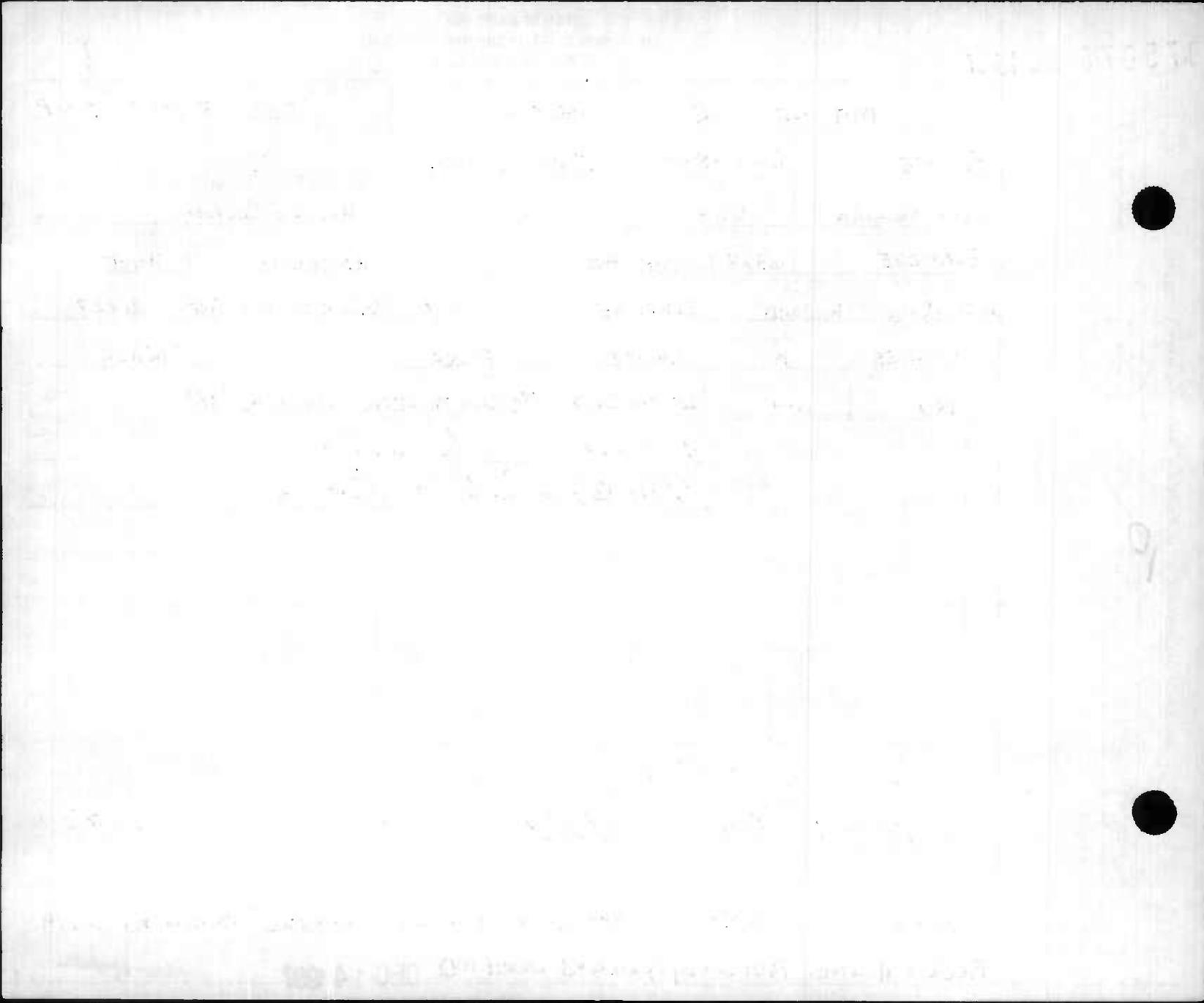
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the death certificate must be held for balance.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8735969

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
MADGE C. HESSON						DEC	8	1987	1:00 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		2b. HOUR	
FEMALE		CAUCASIAN		MONTH JUNE DAY 5 YEAR 1897		90 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
WEST VIRGINIA		USA				HOWARD COUNTY MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
ELKRIDGE		6328 LOUDON AVE		HOUSEWIFE		HOME					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
MARYLAND		HOWARD		ELKRIDGE				6328 LOUDON AVE. 21227			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
		CHARLES	K.	LANTZ	ANNA				TRACY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
NO		N/A		JOANN KWEDAR		SAME AS #13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Loss of blood & Brain</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Multiple hemorrhage to Brain</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> DUE TO, OR AS A CONSEQUENCE OF											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on 12/4/87 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did not) (did not) view the body after death.											
22b. SIGNATURE <i>John O'Hay</i>		22c. DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>12/9/87</i>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/11/87		23c. NAME OF CEMETERY OR CREMATORIAL ARBORVALE CEMETERY		23d. LOCATION CITY OR TOWN ARBORVALE		COUNTY POCOHONTAS		STATE W. VA.	
24. FUNERAL DIRECTOR NAME Heck F.H. Inc.		ADDRESS 7601 SANDY SPRING Rd. LAUREL MD		25a. DATE REC'D. BY REGISTRAR DEC 14 1987		25b. REGISTRAR'S SIGNATURE <i>John O'Hay</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed, it should be forwarded to the funeral director. If the deceased was not buried or cremated within 24 hours of death, the certificate should be detached from the death certificate and sent to the State Dept. of Health and Mental Hygiene prior to burial. It must be retained with the State Dept. of Health and Mental Hygiene prior to burial. Certification of death will be denied if this certificate is not submitted to the State Dept. of Health and Mental Hygiene prior to burial.

IMPORTANT: If Item 23 is marked or Item 18 shows any indication of other traumatic event(s), the medical examiner must be notified.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8735970
REG. NO.

DECEDENT NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR					
Albert Eugene Hooper						10	24	87		10:30 A.M.					
1. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS							
Male	White	October 4	MONTH	DAY	87	MONTHS	DAYS	HOURS	MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8	MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH								
Wisconsin	U.S.A.						Howard County MD.								
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY				
Columbia	8716 Hayshed Ln.					Retired									
13a. STATE MD.	13b. COUNTY Howard	13c. CITY OR TOWN Columbia	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8716 Hayshed Ln. 21045										
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME		FIRST MIDDLE LAST									
Albert		A. Hooper		Alice		Peck									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS 8716 Hayshed Ln. Columbia MD 21045									
No		392-07-9195		Bernice Hooper											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Congestive heart failure</i>												<i>Year</i>			
{ DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary artery disease</i>												<i>Year</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Cerebrovascular insufficiency</i>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
							YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1983 19 27 to 10/24 19 87, that (I) (we) last saw the deceased alive on 10/21 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death.												22b. DATE SIGNED 10/24/87			
22c. SIGNATURE <i>James Denton, MD</i>												22d. DEGREE ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 26 OCT 87		23c. NAME OF CEMETERY OR CREMATORIAL WESTVIEW MEM. P.C.		23d. LOCATION CITY OR TOWN CATONSVILLE		COUNTY BALTIMORE		STATE MD.					
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME		ADDRESS BOX 260 ELMONT, MD 21043		25a. DATE REC'D. BY REGISTRAR NOV 12 1987		25b. REGISTRAR'S SIGNATURE <i>Jane Blanton Kendall</i>									

010
SAC-142 52015



072186 NOV

DIVISION OF VITAL RECORDS, 201 W PRESTON ST., BALTIMORE, MARYLAND 21201
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be delivered for use at the burial/tranqu permiss. Then please remove carbon copies. Page 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation, or removal of body.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury or other traumatic event, the medical examiner will investigate.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																
87 35971 REG. NO.																
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
MARY			K.	HOTTINGER		11	13	87				2:30 PM				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.		
FEMALE			WHITE			MONTH	DAY	YEAR	60	YRS.		MONTHS DAYS		HOURS MIN.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
PENNSYLVANIA			U.S.A.						HOWARD COUNTY							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
COLUMBIA			HOWARD COUNTY GENERAL HOSPITAL			REGISTERED NURSE			HOSPITAL							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			13f. ADDRESS	
MARYLAND			BALTIMORE			CATONSVILLE						6028 MOOREHEAD ROAD			21228	
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST	
FRED						MOESTA			UNKNOWN						UNKNOWN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			CATONSVILLE, MD				
NO			220-30-7381			HAROLD HOTTINGER			6028 MOOREHEAD ROAD			21228				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lobar Pneumonia</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1wk</i>				
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Carcinoma of the lung</i>												<i>6 months</i>				
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Bilateral CVA</i>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>87</i> 11/12 87			19			to <i>87</i> 11/13 87			19		19					
now the deceased alive on <i>87</i> 11/13 87						and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE <i>Scott Maurer</i>			DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>11/13/87</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. SCOTT MAURER			22e. ADDRESS HOWARD COUNTY GENERAL HOSPITAL COLUMBIA, MD.			23d. LOCATION CITY OR TOWN WOODLAWN			COUNTY BALTIMORE			STATE MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 11/16/87			23c. NAME OF CEMETERY OR CREMATORIUM WOODLAWN CEMETERY			23d. LOCATION CITY OR TOWN WOODLAWN			COUNTY BALTIMORE				
24. FUNERAL DIRECTOR LEROY M & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVE. CATONSVILLE MD 21228						25a. DATE REC'D. BY REGISTRAR NOV 17 1987			25b. REGISTRAR'S SIGNATURE <i>Edison L. Dease</i>							
BP																

W.D. 771850

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then place it over carbon paper. Pages 1 and 2 will be filed in the medical examiner's office with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8735972	
1 - FOR STATE REGISTRAR			RACHEL			E. HOWES			REG. NO.		
DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR
RACHEL E HOWES						11 06 87			745	745	PM
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
FEMALE			WHITE			MONTH DAY YEAR			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			83 YRS		
Md. —			USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			9			BALTIMORE CITY OR COUNTY OF DEATH		
COLUMBIA			HOWARD COUNTY GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			Howard County MD		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			12b. KIND OF BUSINESS OR INDUSTRY		
MARYLAND			Howard			LAUREL			Homemaker		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			17. INFORMANT		
EVAN			CARRIE			NO			ADDRESS		
						216 22 0441			RICHIE W. HOWES SAME AS # 13		
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. minutes											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure</u> days											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Bronchitis</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
—			—			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. — 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>October 27, 1987</u> , to <u>November 6, 1987</u> , that (I) (we) last saw the deceased alive on <u>11/06/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did/did not view the body after death.											
22b. SIGNATURE <u>Sue Ann Baum, MD</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>11/06/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Eric Tanenbaum, MD</u>			22e. ADDRESS <u>11085 LITTLE PATUXENT PKWY</u> <u>COLUMBIA, MARYLAND 21044</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL MT. CARMEL			23d. LOCATION SUNSHINE MONT. MD.		
BURIAL			NOV. 10, 1987								
24. FUNERAL DIRECTOR NAME <u>Muriel H. Barber</u>			25a. DATE REC'D. BY REG. OFFR. <u>NOV 16 1987</u>			25b. REGISTRAR'S SIGNATURE <u>Sue Ann Baum, MD</u>					
LAYTONSVILLE, MD. 20879											

1916.10.10

10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 973

1- FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST
Gwendolyn M.

MIDDLE
N.

LAST
IRVING

2a. DATE KNOWN
OF
ESTI-
MATED
12-25 1987

MONTH DAY YEAR
2b. HOUR
1 PM

3. SEX

4. RACE
Cauc.

5. DATE OF BIRTH
MONTH
11 DAY
8 YEAR
14

6. AGE (IN YEARS
LAST BIRTHDAY)
73 yrs.

7. IF UNDER 1 YR.
MONTHS
0 DAYS
0 HOURS
0 MIN
0

8. IF UNDER 24 HRS.
MONTHS
0 DAYS
0 HOURS
0 MIN
0

9c. DATE
PRONOUNCED
DEAD
12-25 1987

MONTH DAY YEAR
2d. HOUR
12:20 PM

7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

N. Carolina

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED
 NEVER MARRIED

WIDOWED DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH
Howard County

MD

10. CITY OR TOWN OF DEATH

Clarksville

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

7422 Oak Crest Lane

21029

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Housewife

12b. KIND OF BUSINESS
OR INDUSTRY

13a. STATE

Maryland

13b. COUNTY

Howard

13c. CITY OR TOWN

Clarksville

13d. INSIDE CITY LIMITS?
YES NO

13e. STREET ADDRESS

7422 Oak Crest Lane

21029

14. FATHER'S NAME

John C Magill

FIRST

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME
FIRST
Rena Heibarger

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

NO

16b. SOCIAL SECURITY NO.

313 50 1089

17. INFORMANT

Irvine B. Irving 7422 Oak Crest Lane

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

Cardiac arrest
(b) *Arterosclerotic Cardio-vascular disease*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES NO

21a. EXTERNAL CAUSE WAS
UNDERLYING OR
CONTRIBUTING CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE NOT WHILE
AT WORK

21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET
CITY OR TOWN
COUNTY
STATE

22a. I certify that I took charge of the remains described above, held on Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE *Thomas F. Herbert*

TITLE (SPECIFY)
M.D. Deputy MEDICAL EXAMINER

DATE SIGNED *12-25-87*

EXAMINER'S NAME
(TYPE OR PRINT)

Thomas F. Herbert

ADDRESS

Ellicott City MD 21043

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE
DEC 29, 1987

23c. NAME OF CEMETERY OR CREMATORIAL
Parklawn

23d. LOCATION
CITY OR TOWN

Rockville

COUNTY
Montgomery Maryland

24. FUNERAL DIRECTOR

NAME

Harry H Witzke Old Columbia Pike Ellicott City

ADDRESS

25a. DATE REC'D. BY REGISTRAR
DEC 28 1987

25b. REGISTRAR'S SIGNATURE

4

1

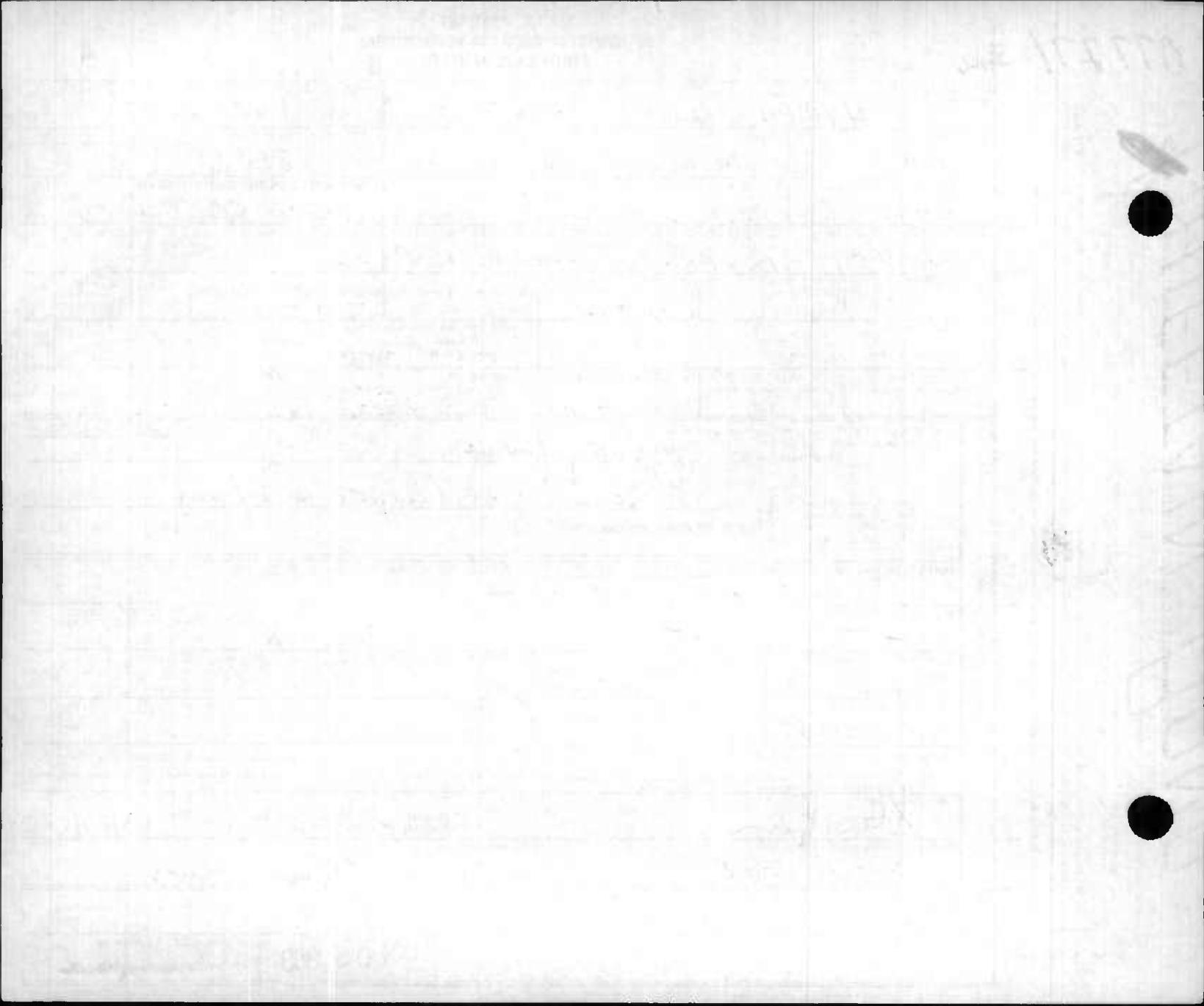
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then pages 1, 2 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, transit, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner shall be notified immediately.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 35974	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
HYMAN NMI					KORTH	12	27	87		M	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
MALE		WHITE		MONTH 04	DAY 23	YEAR 06	81 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH HOWARD County MD.				
10 CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION HOWARD CO. GENERAL HOSP.		12a USUAL OCCUPATION HOME BUILDER			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MD.		13b. COUNTY HOWARD		13c. CITY OR TOWN COLUMBIA			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 6334 CEDAR LANE 21044	
14. FATHER'S NAME GEORGE KORTH				15. MOTHER'S MAIDEN NAME CLARA KORTH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES		16b. SOCIAL SECURITY NO. 186-01-1342		17. INFORMANT MARSHA BARNES - daughter 10301 DAYSTAR CT. COLUMBIA MD.			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				DUE TO, OR AS A CONSEQUENCE OF (b) <i>Severe CHF (congestive heart failure)</i>							
				DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>Document urinary tract infection</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>12/19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>fall</i>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>19</i> , 19 <i>87</i> , to <i>19</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>19</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>Steiner</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/27/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Steiner, Steve</i>		22e. ADDRESS <i>1105 Little Patuxent Parkway</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 12-28-87		23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN			23d. LOCATION CITY OR TOWN			23e. COUNTY	
24. FUNERAL DIRECTOR NAME State Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR JAN 05 1988			25b. REGISTRAR'S SIGNATURE <i>Julie Davidson-Henderson</i>				





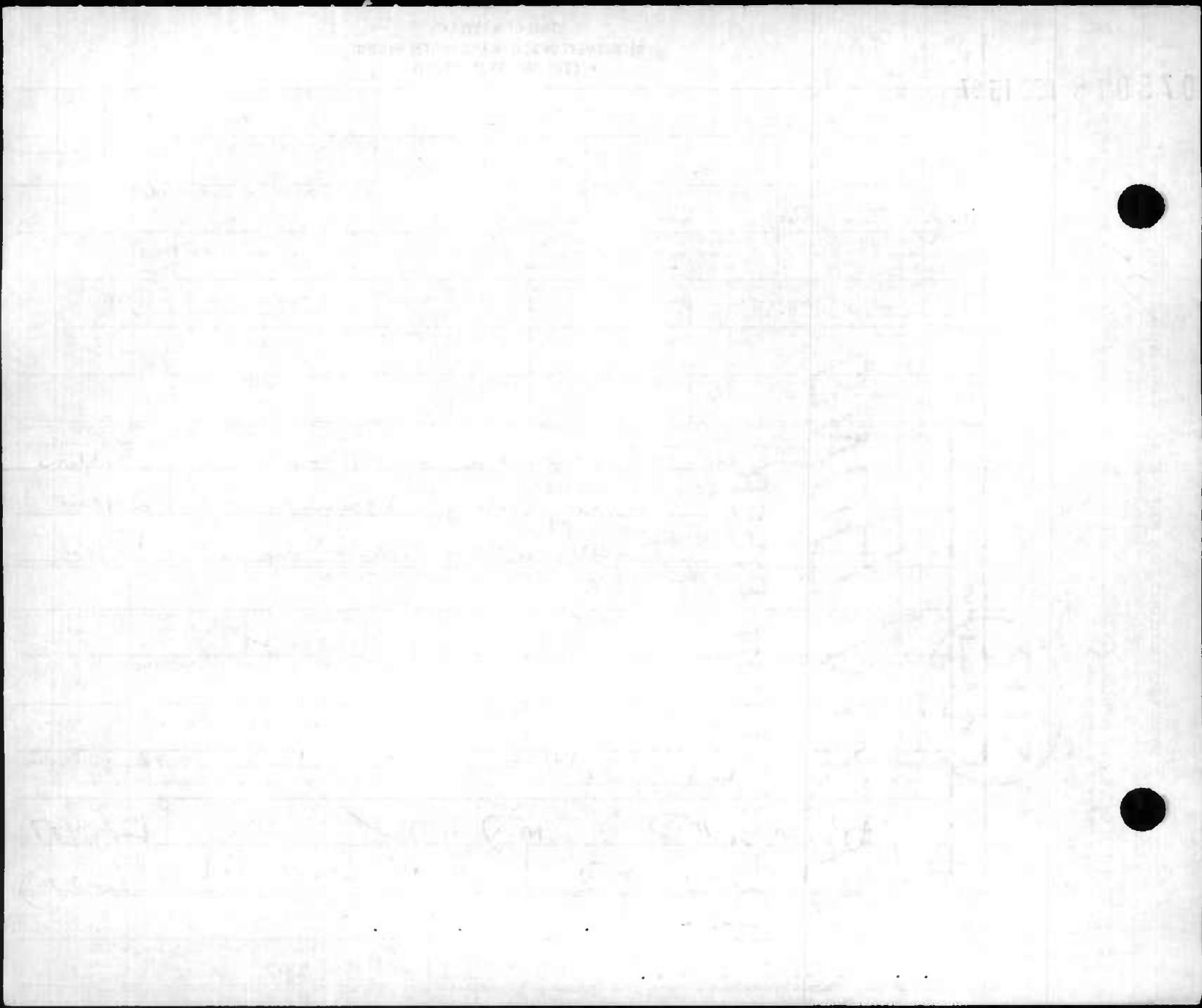
075015 DEC 15 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 states any injury, or other traumatic event, the medical examiner will be notified on arrival.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 35975											
1 - FOR STATE REGISTRAR			2a. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH MONTH DAY YEAR		
BERTHA JACOBS						12-8-87			2b. HOUR		
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH 12 TH 24 04			6. AGE (IN YEARS LAST BIRTHDAY) 82			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY SOUTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD MD.				
10. CITY OR TOWN OF DEATH JESSUP		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 8210 LINCOLN DRIVE		12a. USUAL OCCUPATION (TYPE OR PRINT FOR 90% OF WORKING LIFE) RETIRED			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MARYLAND		13b. COUNTY HOWARD		13c. CITY OR TOWN JESSUP			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 8210 LINCOLN DRIVE 20794	
14. FATHER'S NAME JASPER		15. MOTHER'S MAIDEN NAME MATIDA									
FIRST NO		MIDDLE DEAN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT CHART			ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Probable cardiac arrhythmia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden											
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease 2 years											
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus, insulin dependent 15 yrs.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 12/22 1989 to 12/7 1987, that (I) (we) last saw the deceased alive on 12/1 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Barry F. Lance, M.D.		22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 12/10/87				
23a. PHYSICIAN'S NAME (TYPE OR PRINT) Barry F. Lance, M.D.		22f. ADDRESS 14201 Laurel Park Dr. #223 Laurel, MD									
23b. BURIAL, CREMATION, REMOVAL REMOVAL		23c. NAME OF CEMETERY OR CREMATORIAL MT. ZION CH. CEMT.		23d. LOCATION GREENWOOD CITY OR TOWN COUNTY STATE SOUTH CAROLINA							
24. FUNERAL DIRECTOR NAME E.L. PHILLIPS		ADDRESS 1721 N. MONROE STREET		25a. DATE REC'D. BY REGISTRAR DEC 14 1987			25b. REGISTRAR'S SIGNATURE Julia Davidson-Landau				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and attested to by the funeral director, page 3 should be detached for use in the burial permit. Then please remove carbon paper. Page 4 may be used within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

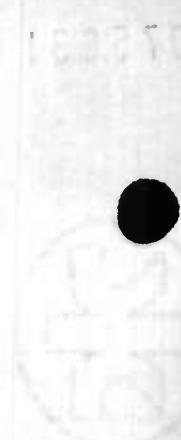
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1 - STATE REGISTRAR		1 - DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
075831 DEC 22 1987		Kenneth C Jewell				Jewell	10/12/87	12	18	87	615P M	
3. SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 72 HRS	
Male		WHITE		10 9 1923			64 YRS		MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		MD.			
W. VA.		U.S.A.					HOWARD					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		Comm.			
ELLICOTT CITY				GUARD			Wash. Sub.					
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE Md.		13b. COUNTY Howard		13c. CITY OR TOWN - ELLICOTT CITY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8560 OLD FREDERICK Rd. 21043			
14. FATHER'S NAME FIRST LEW		MIDDLE JEWELL		15. MOTHER'S MAIDEN NAME FIRST BERTHA			LAST SMITH					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. No		17. INFORMANT THERESA JEWELL			ADDRESS 8560 OLD FREDERICK Rd. ELLICOTT CITY MD. 21043					
18 CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Esophageal Carcinoma, metastatic</u> APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>6 months</u> (c)												
DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (we) attended the deceased from <u>8-27-57</u> , 19 <u>19</u> , to <u>12-18-87</u> , 19 <u>19</u> , that (I) (we) last saw the deceased alive on <u>12-10-87</u> , 19 <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Paul Gormley</u>		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 12/19/87					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>PAUL GORMLEY</u>		22f. ADDRESS 900 Caton Ave Baltimore Md. 21229										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 12-21-87		23c. NAME OF CEMETERY OR CREMATORIAL CRESTLAWN			23d. LOCATION CITY OR TOWN MARRIOTTSVILLE		COUNTY Howard		STATE Md.	
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME		ADDRESS 3871 Old Columbia Pk. ELLICOTT CITY 21043			25a. DATE REC'D. BY REGISTRAR DEC 21 1987							
BP												

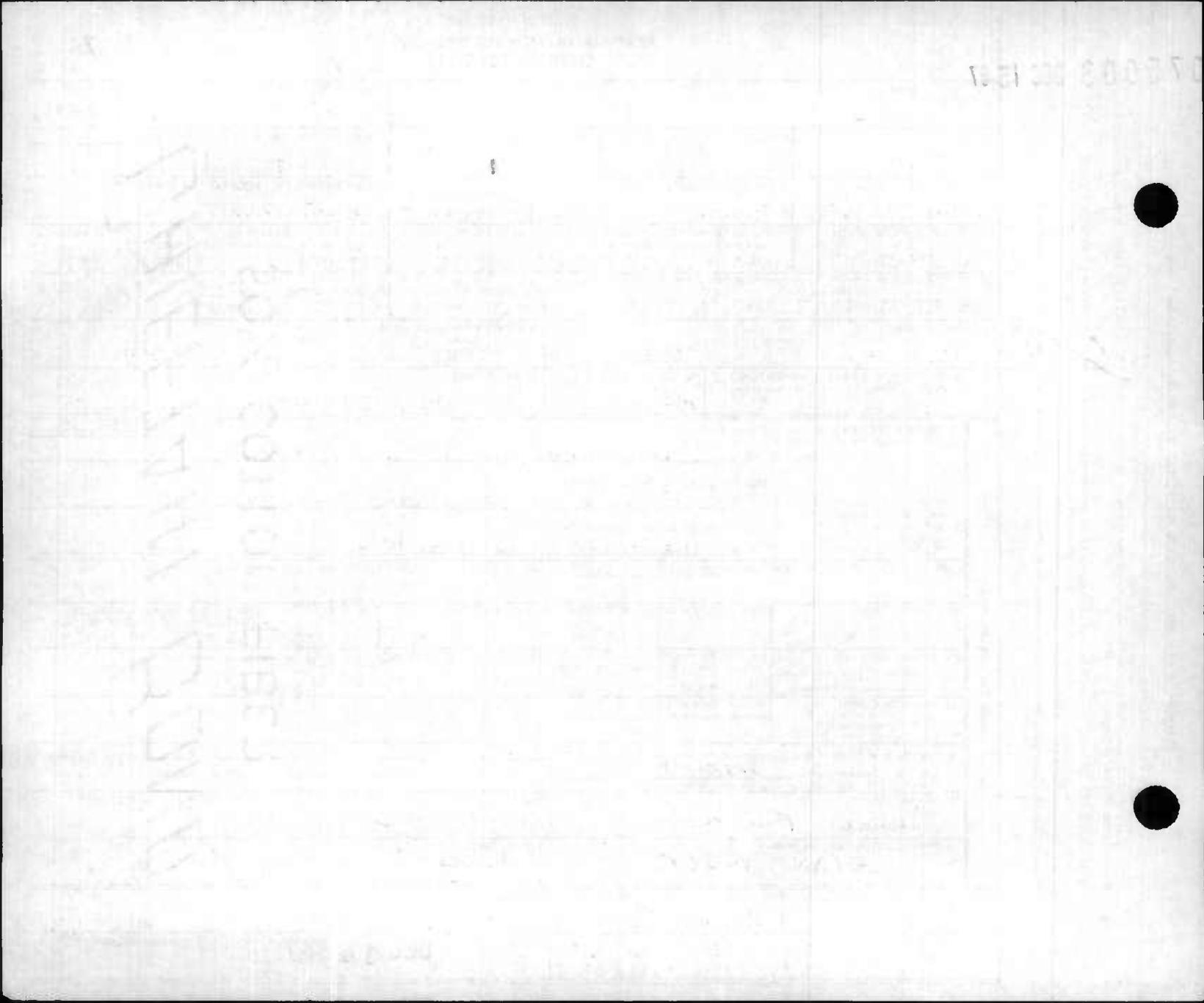
841 MELCO. N.O.R.

W.H. TAYLOR



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 87 35977
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
DANIEL WEBSTER JONES						12	08	87		115 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE		BLACK		MONTH	DAY	YEAR		MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				
WASHINGTON D.C.		U.S.A.						HOWARD COUNTY		MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
COLUMBIA		HOWARD COUNTY GENERAL HOSPITAL		NEW JERSEY		HAMILTON		BOX 21 RAILROAD BLVD.		PULMAN CO.		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
NEW JERSEY		HAMILTON		MIZPAH		YES <input type="checkbox"/> NO <input type="checkbox"/>		BOX 21 RAILROAD BLVD.		9999		
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME								
		CHARLES JONES		VIOLA						HANSFORD		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO		709-094-1823		DANIEL SMITH		MARYLAND 21045		Cardiorespiratory Arrest				
						5806 ALDERLEAF PL. COLUMBIA						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		b) Acute myocardial Infarction										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		c) AS CVD, Diabetes										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12/18/87 19 to 19, that (I) (we) last saw the deceased alive on 12/18/87 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Leean Kuck		DEGREE md		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEVAN KUCK		22e. ADDRESS Howard Co Gen Hosp Columbia md 2904										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/15/87		23c. NAME OF CEMETERY OR CREMATORIAL ROLLING GREEN MEM. PARK		23d. LOCATION CITY OR TOWN WEST CHESTER		STATE PENNSYLVANIA				
24. FUNERAL DIRECTOR LEROY M & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVE CATONSVILLE MD 21228						25a. DATE REC'D. BY REGISTRAR DEC 14 1987		25b. REGISTRATION NUMBER 99999999				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/cremation, or removed if it is marked as being destroyed.

IMPORTANT: If item 21 is marked as being destroyed, the medical examiner must be notified of the event.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8735978	REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
James Wiley Kimbel						November	8	1987		4:45am
3. SEX Male		4. RACE Caucasian	5. DATE OF BIRTH September 14, 1908			6 AGE (IN YEARS LAST BIRTHDAY) 79	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard County				
10 CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cabinet Maker			12b KIND OF BUSINESS OR INDUSTRY U.S. Government	
13a STATE Maryland		13b COUNTY Howard	13c CITY OR TOWN Highland	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 13430 Chris-Mar Court/20777				
14. FATHER'S NAME FIRST William		MIDDLE E.	LAST Kimbel	15. MOTHER'S MAIDEN NAME FIRST Lula		MIDDLE Mae	LAST Lewis			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 229-18-1736 A		17 INFORMANT ADDRESS Betty Millman 13430 Chris-Mar Court Highland, Maryland 20777 (Daughter)						
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		cardiogenic shock				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		{ (b) cardiomyopathy								
(c)		DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NORMAL DUTIES <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a I certify that (I) (this hospital) attended the deceased from 11/7/87 to 11/8/87 , that (I) (we) last saw the deceased alive on 11/8/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE William Flowers MD		DEGREE				22i. DATE SIGNED 11/8/87				
22d PHYSICIAN'S NAME (TYPE OR PRINT) William Flowers MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE November 11, 1987	23c NAME OF CEMETERY OR CREMATORIAL Parklawn Memorial Park		23d LOCATION CITY OR TOWN ROCKVILLE, MARYLAND		23e COUNTY			STATE
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland		25a. DATE REC'D. BY REGISTRAR AND REGISTRAR'S SIGNATURE NOV 16 1987 <i>Deborah Landes</i>								

BP _____

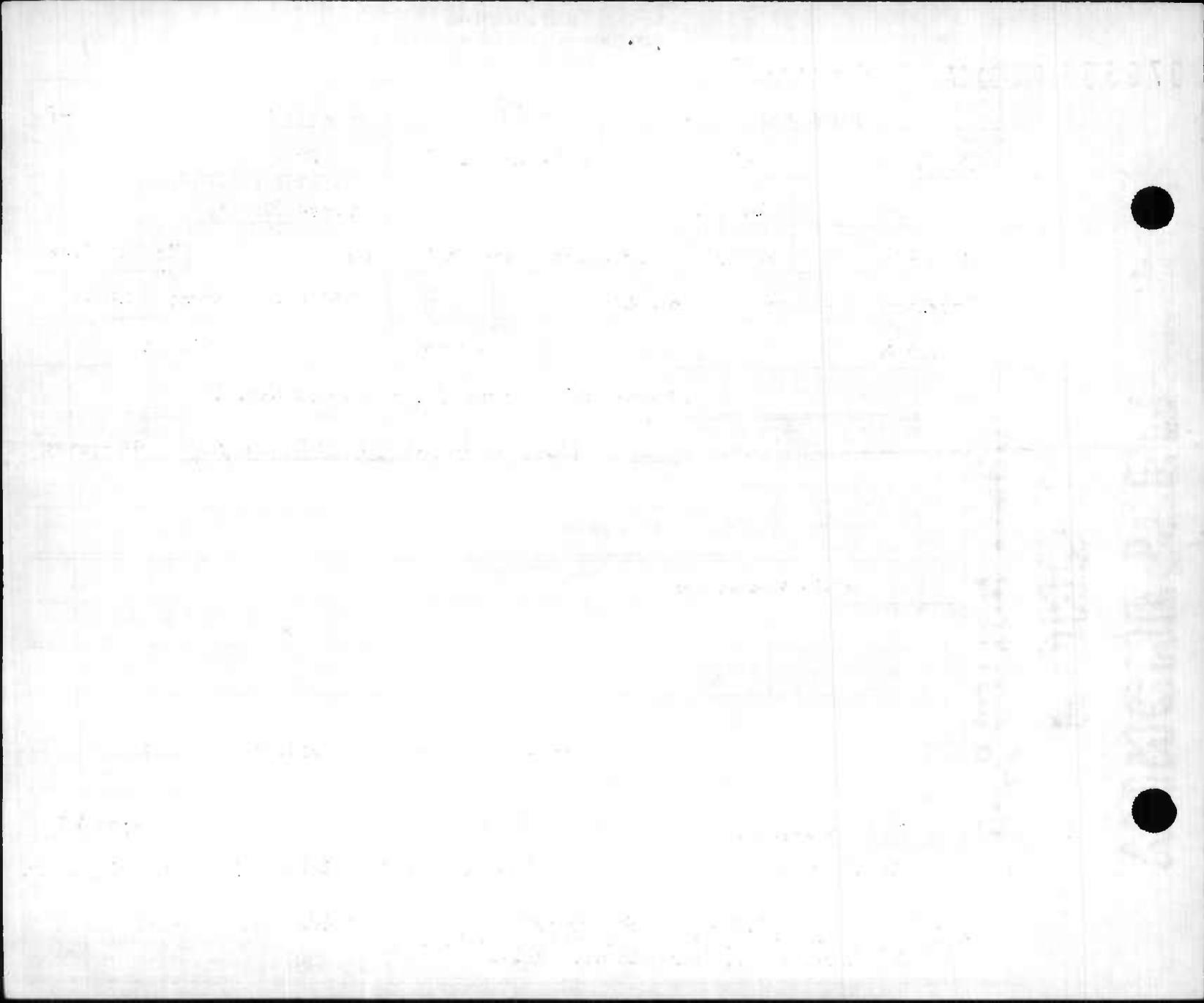
ESTATE EROS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then place duplicate carbon papers, pages 1 and 2 should be placed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial. Retain a copy of the death certificate for your records.

IMPORTANT: If item 21 is marked or item 18 shows any injury, indicate immediately on the medical examination report the method of removal.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
87 35979 REG. NO.											
1 - STATE REGISTRAR	MARIAN R. KIPP			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
1. DECEASED NAME (TYPE OR PRINT)			MARIAN R. KIPP				12/24/87	12/24/87			3:35PM
3. SEX	4 RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE	WHITE		MONTH DAY YEAR July 15, 1927			60	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.					
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse					12b. KIND OF BUSINESS OR INDUSTRY Health Care		
13a. STATE Maryland	13b. COUNTY Howard	13c. CITY OR TOWN Columbia	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 5235 - 4 Brookway 21044					
14. FATHER'S NAME FIRST Ralph	MIDDLE	LAST Robins	15. MOTHER'S MAIDEN NAME FIRST Dorothy			MIDDLE	LAST Gissen				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? NO NO OR UNKNOWN	16b. SOCIAL SECURITY NO. 131-24-6028		17. INFORMANT Bruce Kipp - Same As Sec. 13			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive IntraCerebral Hemorrhage 79 hours										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a HYPERTENSION											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12/21, 1987, to 12/24, 1987, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 12/24/87	
22b. SIGNATURE Kamal Dyal		DEGREE M.B.B.S			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KAMAL DYAL		22e. ADDRESS HOWARD COUNTY GENERAL HOSPITAL, COLUMBIA, MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/28/87		23c. NAME OF CEMETERY OR CREMATORIAL FOREST PARK EAST			23d. LOCATION CITY OR TOWN LEAGUE CITY		COUNTY TEXAS	STATE	
24. FUNERAL DIRECTOR & Russell C. Witzke Funeral Homes P. Eroy M. & Russell C. Witzke Funeral Homes P. 5555 Twin Knolls Rd., Columbia MD. 21045		DATE REC'D. BY REGISTRAR DEC 29 1987			25b. REGISTRAR'S SIGNATURE Julia Sander-Lindale						

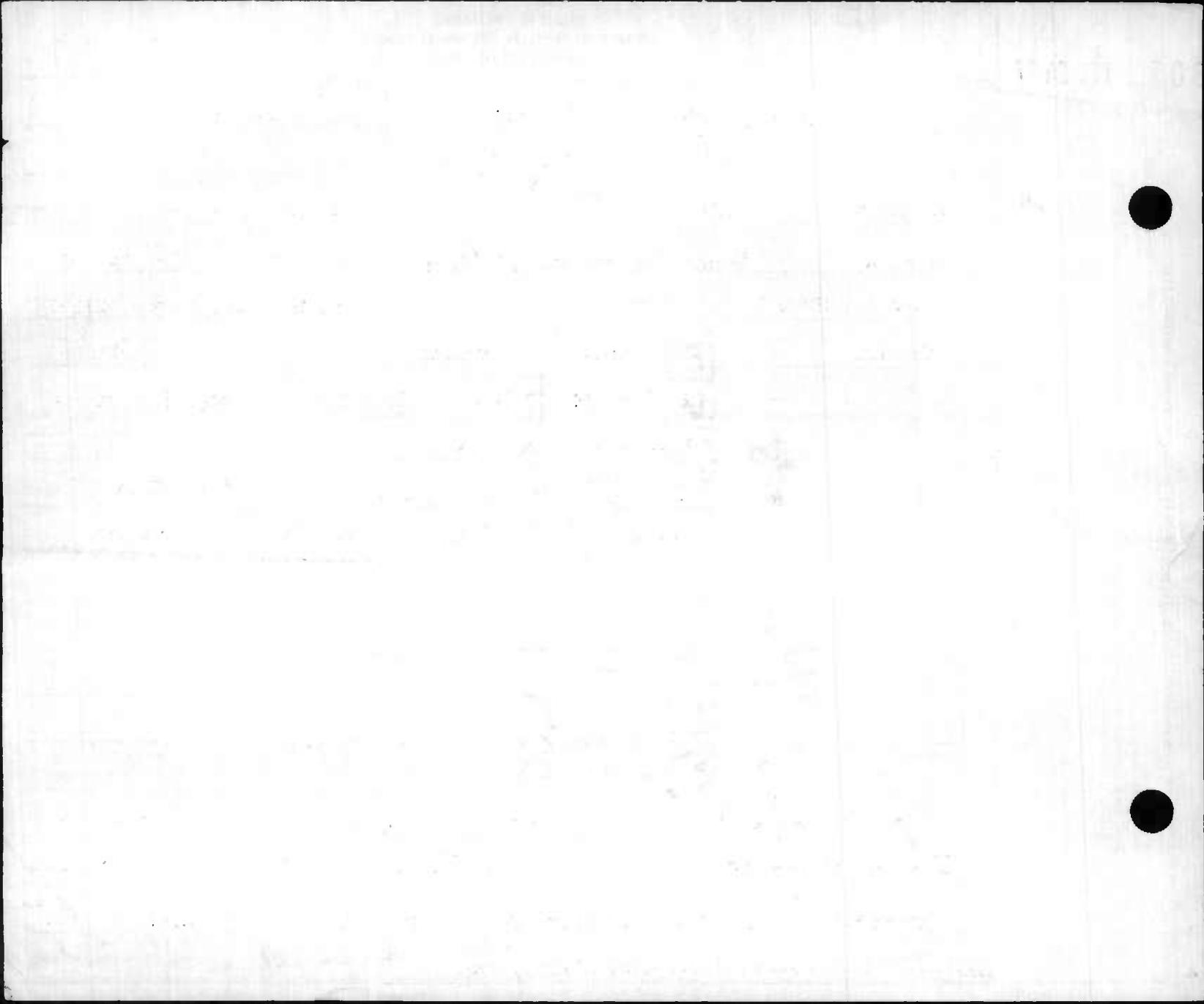


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, Page 3 should be detached for use on the burial/transit permit. Then please remove carbon copy of Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
8735980 REG. NO.											
1 - STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST				2a DATE OF DEATH	MONTH	DAY	YEAR
Garland Lee Klaunberg								12-20-87			26 HOUR 7:00P M
3. SEX		4 RACE		5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		White		MONTH Jan. DAY 12 YEAR 45			42				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Virginia		USA					Howard County				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			
Columbin		Howard County General Hospital			Waitress			Tim Buck TV			
13a STATE Maryland		13b COUNTY Howard		13c CITY OR TOWN Dorsey		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 6908 Magnolia Avenue, 21227			
14. FATHER'S NAME		FIRST Thadius	MIDDLE	LAST Southards	15. MOTHER'S MAIDEN NAME		FIRST Pauline	MIDDLE	LAST UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No		264-70-0474		Roland J. Klaunberg, 6908 Magnolia Avenue							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest											
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatous meningitis 5 weeks											
DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma of lungs - metastatic 10 weeks											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE
22a. I certify that (I) (this hospital) attended the deceased from Nov. 19, 1987, to Dec. 19, 1987, that (I) (we) last saw the deceased alive on Dec. 20, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jon Minford		22c. DEGREE			22d. DATE SIGNED 12-21-87						
22e. ATTENDING PHYSICIAN MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22f. ADDRESS 10806 Hickory Ridge Rd, Columbia MD 21040											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE
Cremation		12/22/87		Security Process Crem.			Catonsville		Baltimore		Md.
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.,		ADDRESS 4107 Wilkers Ave.		25a. DATE REC'D. BY REGISTRAR DEU 23 1987			25b. REGISTRAR'S SIGNATURE John Hubbard Leader				
BP											
DHMH - 16 60M 7/84 (VRA 15, 4)											

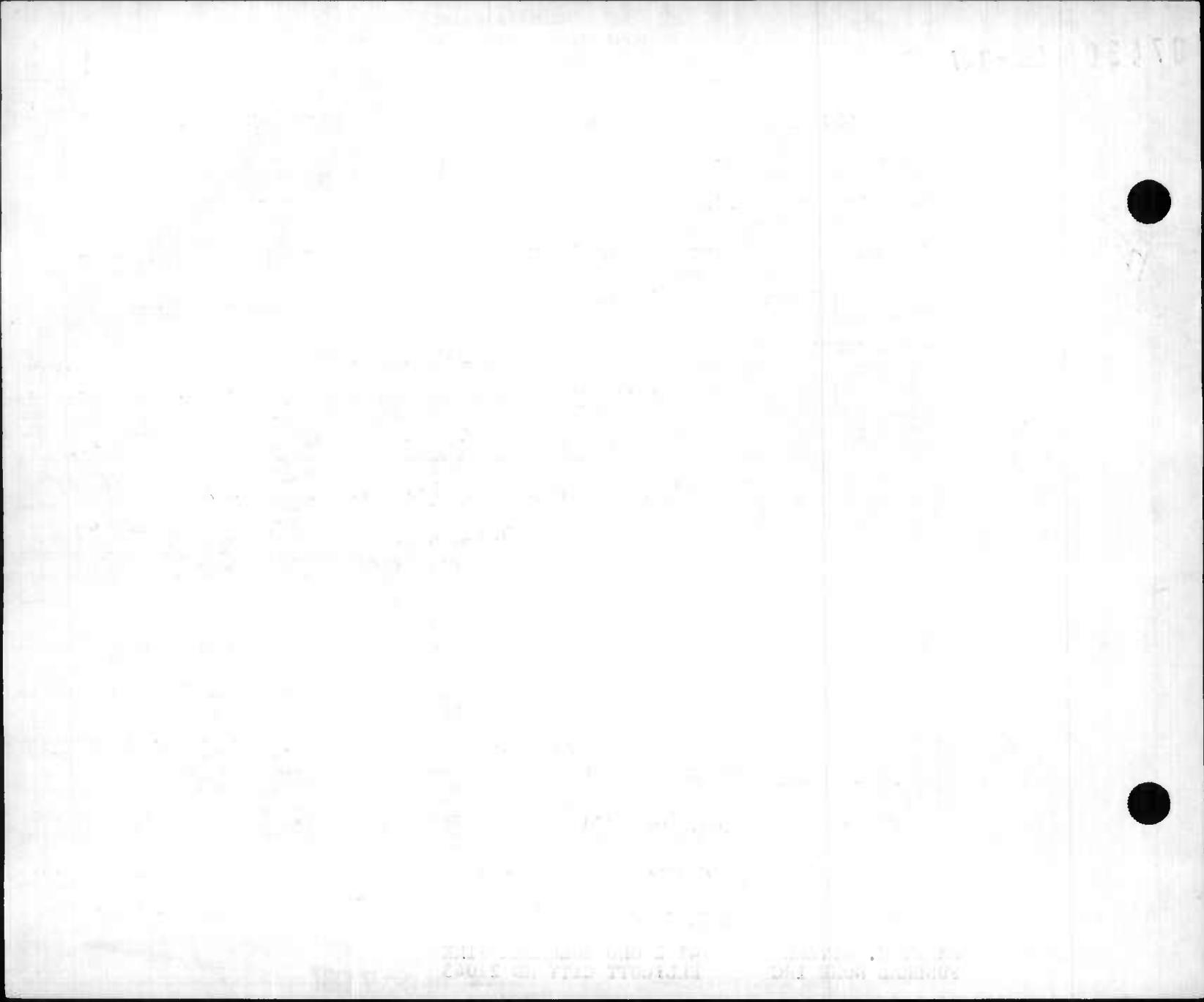


STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
FOR item 5 film SB G634 STATE REGISTRAR 12-14-87 per funeral home			87 REG. NO. 35981										
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
Lois Landolina									December 3, 1987			12:30 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 25, 1987 1932			6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard County			MD.			
10 CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (INCLUDE CITY, GIVE STREET ADDRESS) Howard County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Analyst			12b. KIND OF BUSINESS OR INDUSTRY Insurance						
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6481 Barchink Place		21045			
14 FATHER'S NAME John Moore		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME Bessie Showers		LAST					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b SOCIAL SECURITY NO. 194 24 5470		17 INFORMANT Irene Gibson 5263 Five Fingers Way Columbia		ADDRESS 21045							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) { DUE TO, OR AS A CONSEQUENCE OF (b) Central respiratory failure due to coronary 3 day (c) Thrombosis 3 day PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/30/87 to 12/3/87, shot (I) (we) lost saw the deceased alive on 12/3/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Charles G Taylor MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-4-87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles G Taylor MD		22e. ADDRESS 2 Knoll 1 York Drive, Columbia MD 21045											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE DEC 7, 1987		23c. NAME OF CEMETERY OR CREMATORIAL Crestlawn		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
24. FUNERAL DIRECTOR HARRY H. WITZKE FUNERAL HOME INC		4112 OLD COLUMBIA PIKE ELLIOTT CITY MD 21043		25a. DATE REC'D. BY REGISTRAR DEC 7 1987		25b. REGISTRAR'S SIGNATURE John Witzke							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove and mail to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trouble, medical attention must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy pages 1 and 2. You will be liable within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification section must be filled out entirely.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			2b HOUR				
KAZUKO LAUER						11 07 87			11:45AM				
3 SEX FEMALE		4. RACE ASIAN		5. DATE OF BIRTH MONTH 04 DAY 07 YEAR 29			6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) JAPAN		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.						
10. CITY OR TOWN OF DEATH LAUREL		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8816 CARDINAL FOREST CIRCLE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TECHNICIAN			12b. KIND OF BUSINESS OR INDUSTRY ACCOUNTING						
13a. STATE MARYLAND		13b. COUNTY HOWARD		13c. CITY OR TOWN LAUREL			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8816 CARDINAL FOREST CIR. 20707				
14. FATHER'S NAME FIRST UNKNOWN MIDDLE MIZUSHIMA LAST		15. MOTHER'S MAIDEN NAME FIRST UNKNOWN MIDDLE UNKNOWN LAST UNKNOWN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 573-58-3386			17. INFORMANT BRUCE LAUER			ADDRESS LAUREL MARYLAND 8816 CARDINAL FOREST CIR. 20707				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of Rectum - metastatic DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Chronic anemia, protein, caloric malnutrition, bowel obstruction													
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from JUNE 19 87 to NOV 1 19 87 , that (I) (we) last saw the deceased alive on OCTOBER 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Jon K. Minford</i>		22c. DEGREE VIS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11-9-87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JON MINFORD		22e. ADDRESS 10806 Hickory Ridge Rd, Columbia MD 21044											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 11/09/87		23c. NAME OF CEMETERY OR CREMATORIAL WESTVIEW CREMATORY			23d. LOCATION CITY OR TOWN CATONSVILLE BALTIMORE MD.			COUNTY STATE			
24. FUNERAL DIRECTOR LEROY M & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVE. CATONSVILLE MD 21228					NOV 9 1987			REGISTRAR'S SIGNATURE					

REVIEW COPY

100% VON

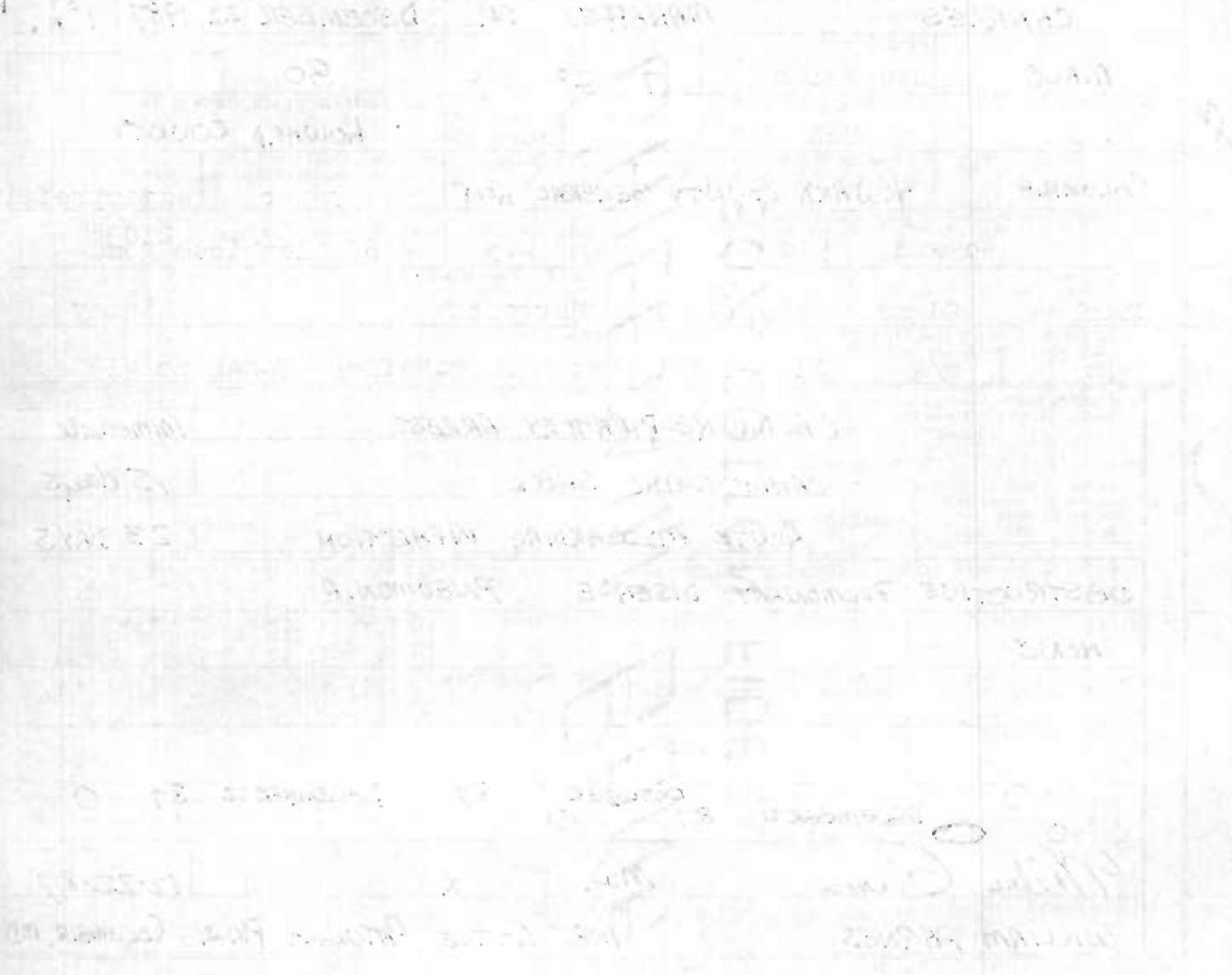
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 23 is marked or Item 18 shows any injury or disease, the medical examiner will be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1. STATE REGISTRAR			87 REG. NO. 35983									
1. DECEASED NAME (TYPE OR PRINT) CHARLES			FIRST Charles	MIDDLE Edgar	LAST Mahaffey	2. DATE OF DEATH MONTH 12 DAY 22 YEAR 87			HOUR 159			
3. SEX Male MALE			4 RACE Caucasian		5. DATE OF BIRTH MONTH 7 DAY 28 YEAR 10			6. AGE (IN YEARS LAST BIRTHDAY) 77			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY N. C.			7b. CITIZEN OF WHAT COUNTRY? USA		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.				
10. CITY OR TOWN OF DEATH COLUMBIA			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD COUNTY GENERAL HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bus. Owner.			12b. KIND OF BUSINESS OR INDUSTRY Waterproffing				
13a. STATE MD			13b. COUNTY Howard	13c. CITY OR TOWN Dayton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 4085 Linthicum Road 21036				
14. FATHER'S NAME FIRST Charles MIDDLE Edgar LAST Mahaffey Sr.			15. MOTHER'S MAIDEN NAME FIRST Margaret MIDDLE Linney LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Leona E. Mahaffey			ADDRESS Sames as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOGENIC SHOCK 15 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE MYOCARDIAL INFARCTION 23 DAYS												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a OBSTRUCTIVE PULMONARY DISEASE PNEUMONIA												
19a. DATE OF OPERATION NONE			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from OCTOBER 19 87 to DECEMBER 22 19 87 , that <input type="checkbox"/> (we) last saw the deceased alive on DECEMBER 21 19 87 , and that in my <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did <input type="checkbox"/> view the body after death.												
22b. SIGNATURE <i>Willie Barnes</i>			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 12-22-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM PARFES			22e. ADDRESS 11085 LITTLE PATUXENT PKWY COLUMBIA, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-24-87			23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Mem. Pk			23d. LOCATION CITY OR TOWN Baltimore COUNTY MD STATE			
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home, Catonsville, MD			ADDRESS			25a. DATE REC'D. BY REGISTRAR DEC 23 1987			25b. REGISTRAR'S SIGNATURE <i>John Lindale</i>			
DHMH - 16 60M 7/84 (VRA 15, 4)												

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76886 DEC 31 87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury or other traumatic event, the medical examiner may be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
8735984 REG. NO.													
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST Thomas			MIDDLE Lee		LAST McCarriar		
2a. DATE OF DEATH			MONTH 12/30/87			DAY			YEAR				
2b. HOUR			8:00 A.M.										
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				
Male			White			8 th MONTH 3 rd DAY 1919			68 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland			U.S.A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Howard MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Columbia			9918 Dellwood Ave.			Analyst U.S. Government							
13a. STATE Maryland			13b. COUNTY Howard			13c. CITY OR TOWN Columbia			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13e. STREET ADDRESS Columbia, Md. 21046													
14. FATHER'S NAME FIRST Thomas			MIDDLE L			LAST McCarriar			15. MOTHER'S MAIDEN NAME FIRST Myrtle				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT Virginia McCarriar			ADDRESS 9918 Dellwood Ave. Columbia, Md. 21046				
Yes			WW 11										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of colon with metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF <u>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</u>													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>17 years</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____							
22a. I certify that at this hospital attended the deceased from <u>1986</u> , 19 th , to <u>December 30</u> , 19 th (we) lost saw the deceased alive on <u>Dec 30</u> , 19 th 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Charles E Taylor</u>			22c. DEGREE m)			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 12-30-87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Charles E Taylor</u>			22e. ADDRESS <u>2 Knoll North Driv. Columbia, Md. 21045</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 2, 1988			23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park			23d. LOCATION CITY OR TOWN Baltimore				
24. FUNERAL DIRECTOR HARRY H. WITZKE FUNERAL HOME INC			4112 OLD COLUMBIA PIKE ELLIOTT CITY MD 21043			25a. DATE REC'D. BY REGISTRAR DEC 31 1987			25b. REGISTRAR'S SIGNATURE <u>John J. Witzke</u>				

077684 JAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be held responsible.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
8735985 REG. NO.												
1. DECEDÆD NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	
OTTIS					McCOLLAM	DEC. 22, 1987					100 PM	
3. SEX			4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			2d. HOUR		
MALE			WHITE	MONTH	DAY	YEAR	79 yrs			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
WEST VIRGINIA			U.S.A.						HOWARD COUNTY MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
HIGHLAND			14115 RT. 108			ACCT.			SOUTHERN RAIL.			
13a. STATE			13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
MARYLAND			HOWARD	HIGHLAND						14115 RT. 108; 20777		
14. FATHER'S NAME			FIRST CEPHAS	MIDDLE C.	LAST McCOLLAM	15. MOTHER'S MAIDEN NAME			LAST WAMSLEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
NO			- 1579-09-0127			MARGARITA T. McCOLLAM			14115 RT. 108 HIGHLAND MD 20777			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Obstructive Pulmonary Disease 4 years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF												
(c) DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Acute Bronchitis												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) this hospital attended the deceased from saw the deceased alive on Dec 10 1987, and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body of the deceased.					1985			22 Dec 1987				
22b. SIGNATURE					DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		Lewis Kellert, MD.			ADDRESS 4000 Olney Laytonsville Rd. Olney, MD 20832						12/22/87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE		
CREMATION		23 DEC 87		WESTVIEW MEM. PK.		CATONSVILLE		BALTIMORE		MD.		
24. FUNERAL DIRECTOR NAME		John Dallas Flash Moosey		SHACK FENWICK HOME ELICOTT CITY MD 21042		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
						JAN 7 1988						

8877 MAIL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

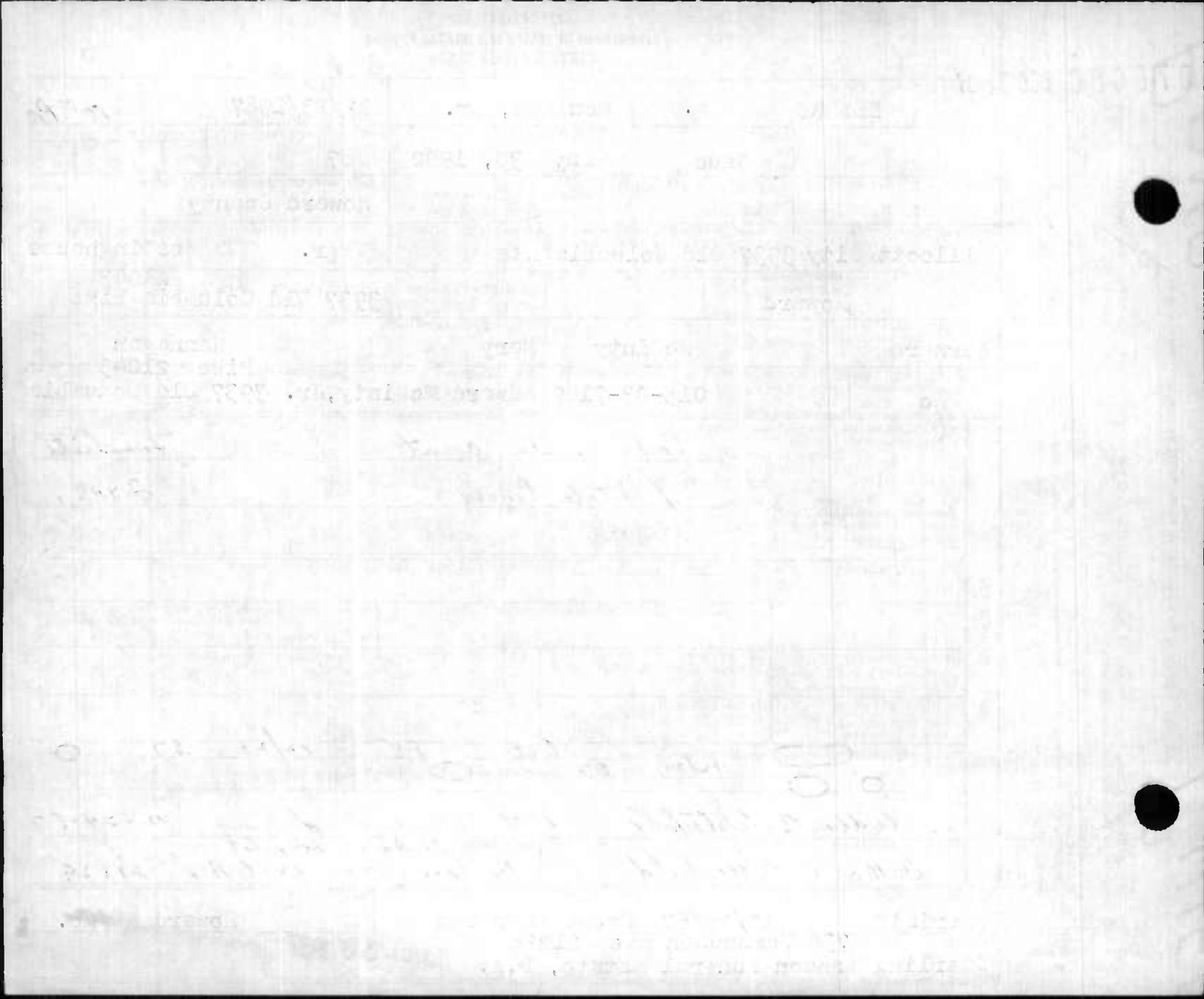
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/trans permit. Then please remove carbon paper. Pages 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18 showing any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
REG. NO. 35986											87				
1 - STATE REGISTRAR			DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
EDWARD			F. McGINTY, Sr.						12/23/1987			1000 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
M		Cauc		May 30, 1900			87								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard County			MD.		
Pa		USA													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Ellicott City		3937 Old Columbia Pike					Mgr.			Westinghouse					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3937 Old Columbia Pike			21043		
Md		Howard													
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME LAST			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			17. INFORMANT Edward McGinty, Jr.			ADDRESS Pike 21043		
				Mary			16b. SOCIAL SECURITY NO. 015-03-7189						Hannagan		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <i>Prostate Cancer</i>												2 yrs.			
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Prostate Cancer</i>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 19 85</i> to <i>12/23 1987</i> , that (I) we last saw the deceased alive on <i>12/21 1987</i> , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) we did not view the body after death.															
22b. SIGNATURE <i>William C. Waterfield</i>		22c. DEGREE <i>MS</i>		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22e. DATE SIGNED <i>12-24-87</i>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>William C. Waterfield</i>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/26/87		23c. NAME OF CEMETERY OR CREMATORIAL Crest Lawn Cem			23d. LOCATION CITY OR TOWN			COUNTY		STATE			
24. FUNERAL DIRECTOR NAME Sterling Ashton Funeral Estate, P.A.		ADDRESS 736 Edmondson Ave 21228		25a. DATE REC'D. BY REGISTRAR DEC 30 1987			25b. REGISTRAR'S SIGNATURE <i>John J. Hennessy</i>								



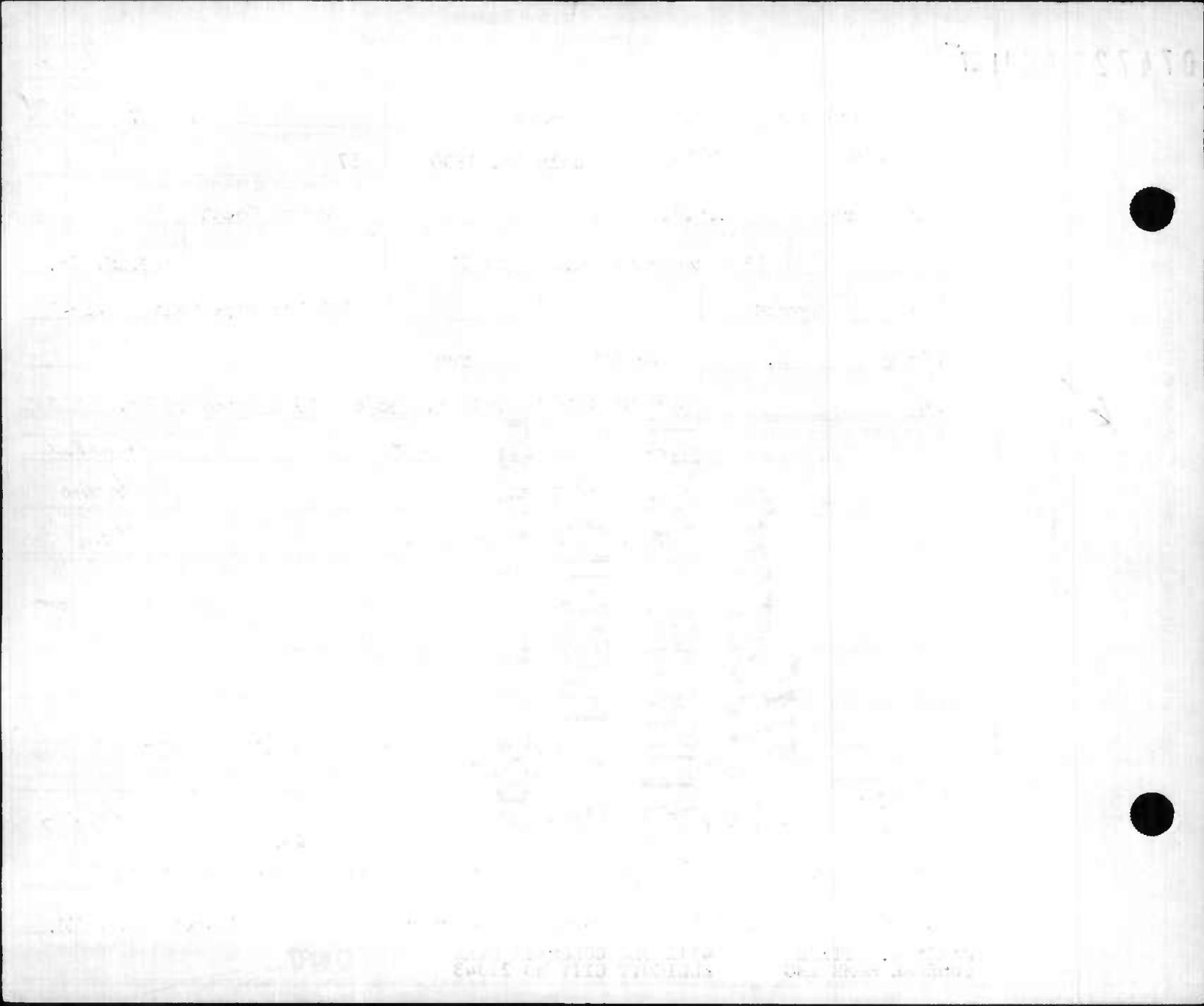
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifying physician must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
87 35937 REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR
Doloris J. Meade						12			7	87	10:00 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		MONTH DAY YEAR July 18, 1930		57			MONTHS	YEARS	HOURS	MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Kentucky		U.S.A.				Howard County						
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY					
		3502 Rosemary Lane		21043			B.G.&E. Co.					
13a STATE Md.		13b COUNTY Howard		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE 3502 Rosemary Lane 21043			
14. FATHER'S NAME FIRST Walter		MIDDLE C.		LAST Caudill		15. MOTHER'S MAIDEN NAME FIRST Grace			LAST			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No		400-36-9225		Lewis E. Meade			3502 Rosemary La. 21043			Somewhat 6 mo		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CNS Metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic adenocarcinoma</u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/6/87, 1987, to 7/18/87, 1987, that (II) (we) last saw the deceased alive on 11/20/87, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												
22b. SIGNATURE <u>Wm C Waterfield MD</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/8/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Wm C Waterfield MD</u>		22e. ADDRESS <u>St Agnes Hospital 900 Caton Ave Baltimore MD 21229</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 12/9/87		23c. NAME OF CEMETERY OR CREMATORIAL Crestlawn Cemetery			23d. LOCATION CITY OR TOWN			COUNTY	STATE	
24. FUNERAL DIRECTOR <u>HARRY H. WITZKE</u> FUNERAL HOME INC		4112 OLD COLUMBIA PIKE ELLIOTT CITY MD 21043			25a. DATE REC'D. BY REGISTRAR DEC 10 1987			25b. REGISTRAR'S SIGNATURE <u>Jeanne L. Mandell</u>				



073138 NOV 25 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 2 and 3 would be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 7 3 5 9 8 8

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Bernice					Melbourne	November 12, 1987				4 am	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		white		MONTH	DAY	YEAR	77	YEARS	MONTHS	DAYS	HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U S A						Howard MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN STATE, GIVE STATE ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Woodbine		Bryan Nursing Home		housewife		home					
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
Maryland		Prince George	Laurel			333 Talbott Avenue 20707					
14. FATHER'S NAME		LAST		15. MOTHER'S MAIDEN NAME		LAST					
Samuel J. Grady				Georgia Lee Clatterbuck							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
no		578-46-9925		P G Melbourne 3rd 16901 Melbourne Drive Laurel Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
IMMEDIATE CAUSE (a)		Gastrointestinal Cerebral hemorrhage									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		5-8 mo.									
(b)		DUE TO, OR AS A CONSEQUENCE OF Common lymphoid cancer									
(c)		DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (he/she) attended the deceased from 1985, 19 to Nov 10, 1987, that (I) (we) lost		saw the deceased alive on Nov 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						Nov. 13, 1987					
Robert C. Wingfield M.D.		333 Prince George St. Laurel, Md. 20707									
23a. BURIAL, CREMATION, REMOVAL (SPECIAL)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY, TOWN		23e. STATE			
Burial		Nov. 14, 1987		Fort Lincoln Cem.		Brentwood		Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS		DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Donaldson Funeral Home, Laurel, Md.				NOV 19 1987		Julia Reiter, R.N.					

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

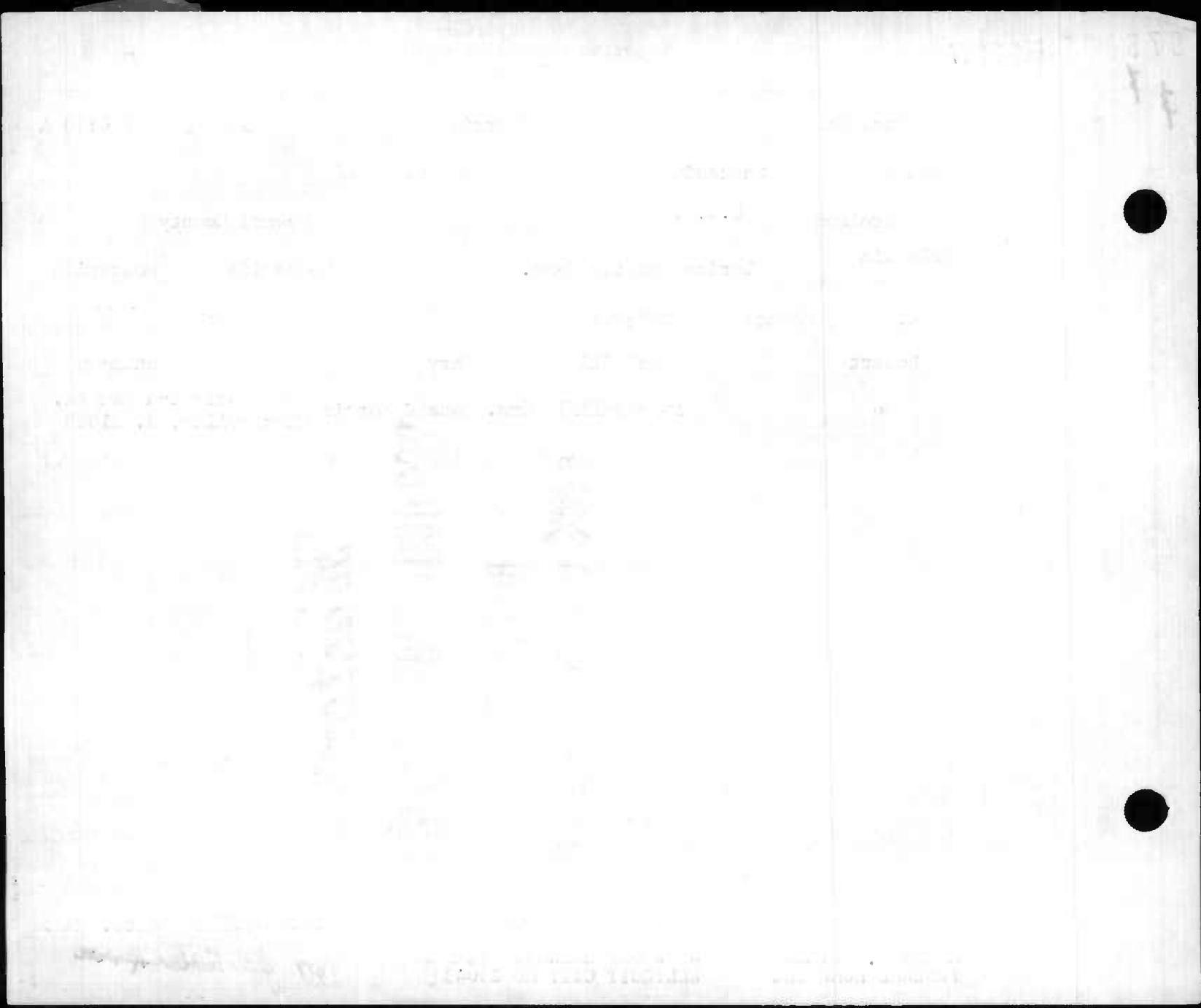
REG. NO. 87 35989

1. DECEASED NAME (TYPE OR PRINT) Lucinda			MIDDLE Morris			2e. DATE OF DEATH MONTH DAY YEAR 12 30 87				2b. HOUR 4:40 A.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 8 16 01		6. AGE (IN YEARS LAST BIRTHDAY) 86		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE COUNTRY Ireland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.					
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lorien Nursing Conv.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Housewife			
13a. STATE Md.		13b. COUNTY Howard		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 34 Cedar Lane 63		21044	
14. FATHER'S NAME FIRST Robert		MIDDLE McNeill		LAST		15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE		LAST unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 165-03-1357		17. INFORMANT Mrs. Donald Morris		ADDRESS 13530 Brighton Dam Rd. Clarksville Md. 21029				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) organic brain syndrome DUE TO, OR AS A CONSEQUENCE OF (b) ASCVI . Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. { DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from JUNE 1987 to December 19 87 , that (I) (we) last saw the deceased alive on 12/24 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) did not view the body after death.											
22b. SIGNATURE R. McNeilly MD		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/30/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROLODRUG BEST		22e. ADDRESS 2850 Ridge Rd. Suite 104 Ellicott City Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec. 30, 1987		23c. NAME OF CEMETERY OR CREMATORIAL Westview		23d. LOCATION CITY OR TOWN Catonsville		COUNTY Balto.		STATE Md.	
24. FUNERAL DIRECTOR HARRY H. WITZKE FUNERAL HOME INC		25a. DATE REC'D. BY REGISTRAR DEC 31 1987				25b. REGISTRAR'S SIGNATURE J. Saider					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified directly.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in his funeral director's office, it should be detached for use as the burial/transit permit. Then please remove carbon paper from the back of this certificate and mail it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
3 / REG. NO. 315990											
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
R MARSHALL Henry Mullis						11 - 14 - 87			10 59 AM		
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
M ALE		CAUCASIAN		03 06 98			89			IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD			MD.	
Mint Hill, N.C.		USA									
10. CITY OR TOWN OF DEATH COLUMBIA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard Co. General Hosp.									
13a. STATE Md.		13b. COUNTY Howard		13c. CITY OR TOWN Savage			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 9108 Balto. Str. 20763	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Keisler									
James V. Mullis											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT Marshall S. Mullis Lusby, Md. 20657			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio pulmonary arrest + DUE TO, OR AS A CONSEQUENCE OF (b) renal failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) urinary tract infection APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH acute				
n/a		n/a 249-22-1636									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 gastro intestinal bleed											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET 19 82 CITY OR TOWN 14/14 COUNTY 19 81 STATE						
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE Marlene											
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Marlene											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/16/87		23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Cemetery Jessup Howard Md.			23d. LOCATION STREET CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME Fleck Funeral Home, Inc. ADDRESS 7601 Sandy Spring Road Laurel, Md. 20701					25a. DATE REC'D. BY REGISTRAR NOV 18 1987			25b. REGISTRAR'S SIGNATURE Julia Davidson-Lund			

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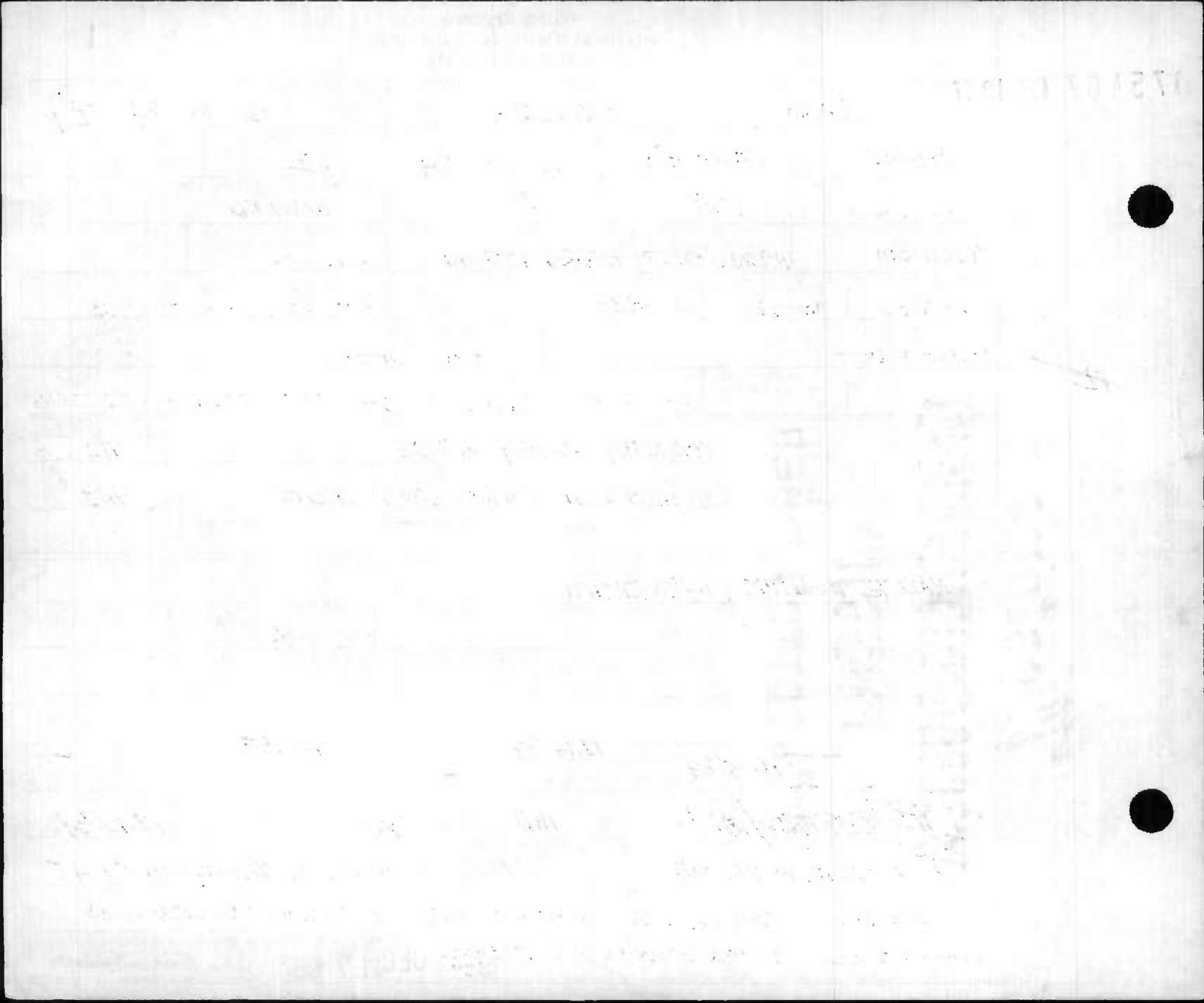
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the attending physician, it should be delivered for use as the transportation permit. Then please remove carbon papers, sign and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 37 35991
1 - STATE REGISTRAR			DECEASED NAME FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			2b HOUR	
JEANNE S. NICHOLSON						12 15 87			12 ³⁹ PM	
3. SEX FEMALE		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 26 24		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
10. CITY OR TOWN OF DEATH COLUMBIA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD COUNTY GENERAL HOSPITAL		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9501 Mellenbrook Rd 21045		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Columbia		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Berry				
14. FATHER'S NAME FIRST MIDDLE LAST Arthur R Storm		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) No 384 22 0354		17. INFORMANT John A Nicholson		ADDRESS 9501 Mellenbrook RD 21045		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY DISEASE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YRS								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE								
		DUE TO, OR AS A CONSEQUENCE OF (c) 								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a DIABETES MELLITUS; HYPERTENSION										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (initials) attended the deceased from 12.14.87 , 19_____, to 12.15.87 , 19_____, that (I) (initials) saw the deceased alive on 12.15.87 , 19_____, and that in (my) (initials) opinion death occurred on the date and hour and from the causes stated above, (I) (initials) did not view the body after death.										
22b. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12.15.87						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE DEC 16, 1987		23c. NAME OF CEMETERY OR CREMATORIAL Wesview Memorial Pk		23d. LOCATION CITY OR TOWN Catonsville COUNTY Balto., Md STATE				
24. FUNERAL DIRECTOR Harry H Witzke 4112 Old Columbia Pike Ellicott City		25a. DATE REC'D. BY REGISTRAR DEC 17 1987		25b. REGISTRAR'S SIGNATURE Julia Dawson-Readace						



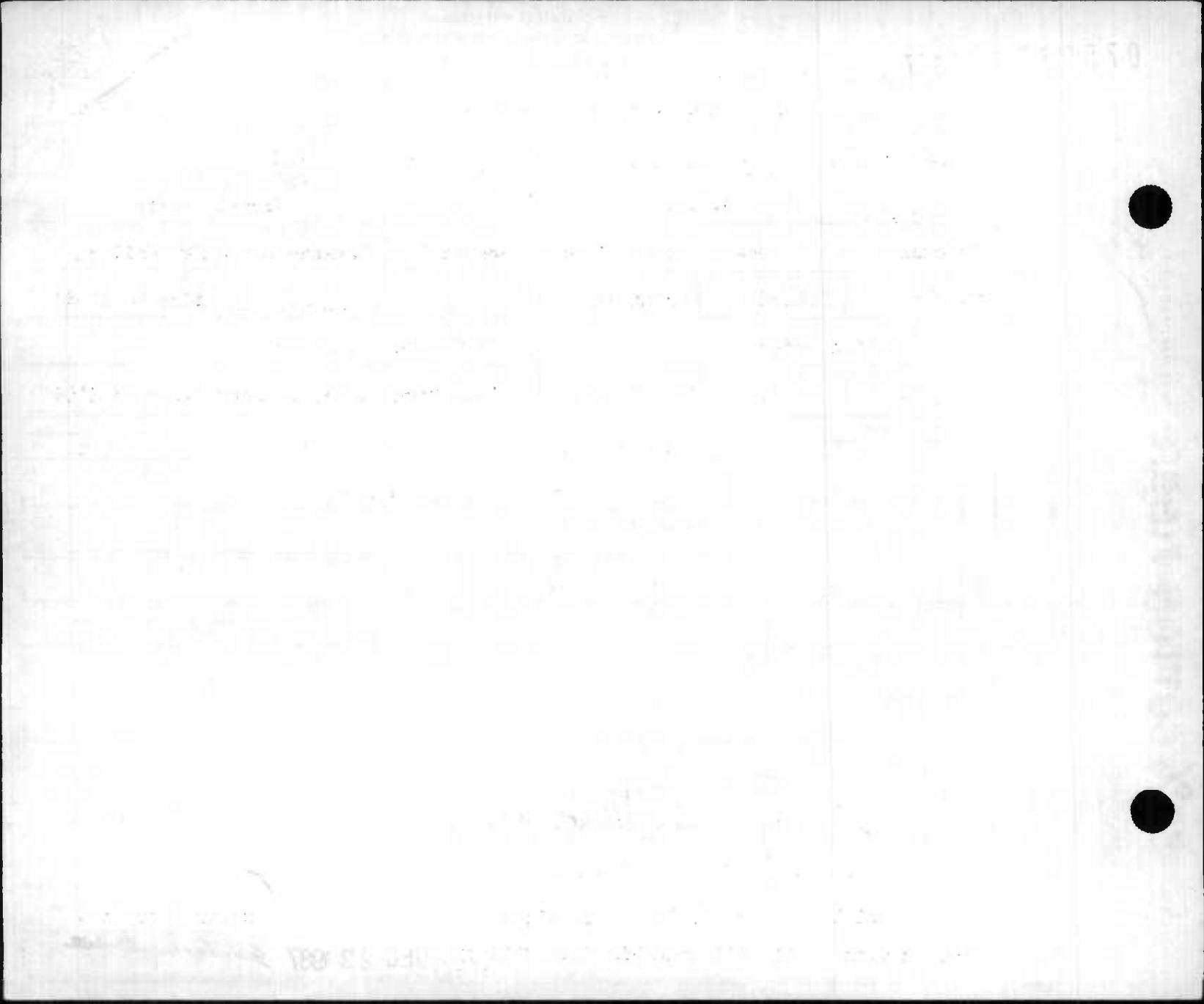
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
87 35992											REG. NO.				
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR			
VIRGINIA Virginia C. Payne PAYNE						7	12	17	87	8:50 P.M.					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS		
<input checked="" type="checkbox"/> Female		CAUC.		MONTH	DAY	YEAR	72	YRS	MONTHS	DAYS	HOURS	MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland		U.S.A.					Howard County								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Columbia		Howard County General Hospital										Retired Community College		MD.	
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Columbia			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 10799 Hickory Ridge Rd 21044					
14. FATHER'S NAME		FIRST William Potts	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST Elizabeth	MIDDLE	LAST Weibrecht					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT			ADDRESS								
No		217 07 8867		William Payne			10799 Hickory Ridge Rd 21044								
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ischemic bowel, bowel infarction</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>complicated myocardial infarction</u>															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>recurrent gastrointestinal hemorrhage</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 12/17/87			
22b. SIGNATURE <u>Gary Alan Miles</u>		22c. DEGREE Mrs		ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
GARY ALAN MILES															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL CRESTLAWN			23d. LOCATION CITY OR TOWN			23e. COUNTY Howard					
Burial		Dec 21, 1987		Crestlawn						Maryland					
24. FUNERAL DIRECTOR Harry H Witzke 4112 Old Columbia Pike Elliott City		25a. DATE REC'D. BY REGISTRAR DEC 22 1987		25b. REGISTRAR'S SIGNATURE <u>John W. Witzke</u>											
BP															
DHMH - 16 60M 7/84 (VRA 15, 4)															



074158 DEC

1 -
STATE
REGISTRAR

767

EVELYN FITZGERALD POLLOCK

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO.

35993

X **Important if Item 2 is marked or item 18 shows any injury or other traumatic event, the medical certificate must be signed by the attending physician**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be delivered for use on the burial-tranfer permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

With the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal

1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
Evelyn FITZGERALD			Pollock			12-03-87			10 PM					
1. SEX		4 RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
FEMALE		Cauc WHITE		MONTH DAY YEAR			76 YRS			IF UNDER 1 HRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			MONTHS DAYS			MONTHS HOURS MIN.				
TENNESSEE		U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13b. KIND OF BUSINESS OR INDUSTRY			MD.				
COLUMBIA		HOWARD COUNTY GENERAL HOSPITAL		HOUSE WIFE			HOWARD COUNTY			OWN HOME				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			21043	
MARYLAND		HOWARD		ELLIOTT						3004 NORTH RIDGE ELLICOTT CITY				
14. FATHER'S NAME		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME			FIRST MIDDLE LAST			ROSE	
ALEX		W.		NEELY			ORA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT			17. ADDRESS			COLUMBIA MD.			21045	
NO		165-12-2068		BARBARA BAIRD 7297 SWAN POINT WAY										
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min.														
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Deep Vein thrombosis</u> UNKNOWN														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Diabetes Mellitus</u>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE	
22a. I certify that (I) (the hospital) attended the deceased from Nov. 19, 87, to 12/03, 87, that (I) (we) last saw the deceased alive on 12/03/87 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.														
22b. SIGNATURE <u>B.S. Minchew</u>		22c. DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 12/03/87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 2850 N. Ridge Rd. Ellicott City, Md 21043												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE BURIAL 12/7/87		23c. NAME OF CEMETERY OR CREMATORIAL ROSE HILL CEMETERY			23d. LOCATION CITY OR TOWN HUMBOLDT			COUNTY TENNESSEE			STATE	
24. FUNERAL DIRECTOR LEROY M. & RUSSELL WITZKE FUNERAL HOME OF COLUMBIA 5555 TWIN KNOLLS ROAD COLUMBIA MARYLAND 21045														
25. DATE REC'D. BY REGISTRAR <u>REC - 4 1987</u> REGISTRAR'S SIGNATURE <u>J. L. Johnson</u>														

W 7-31-31470

41-21470-1

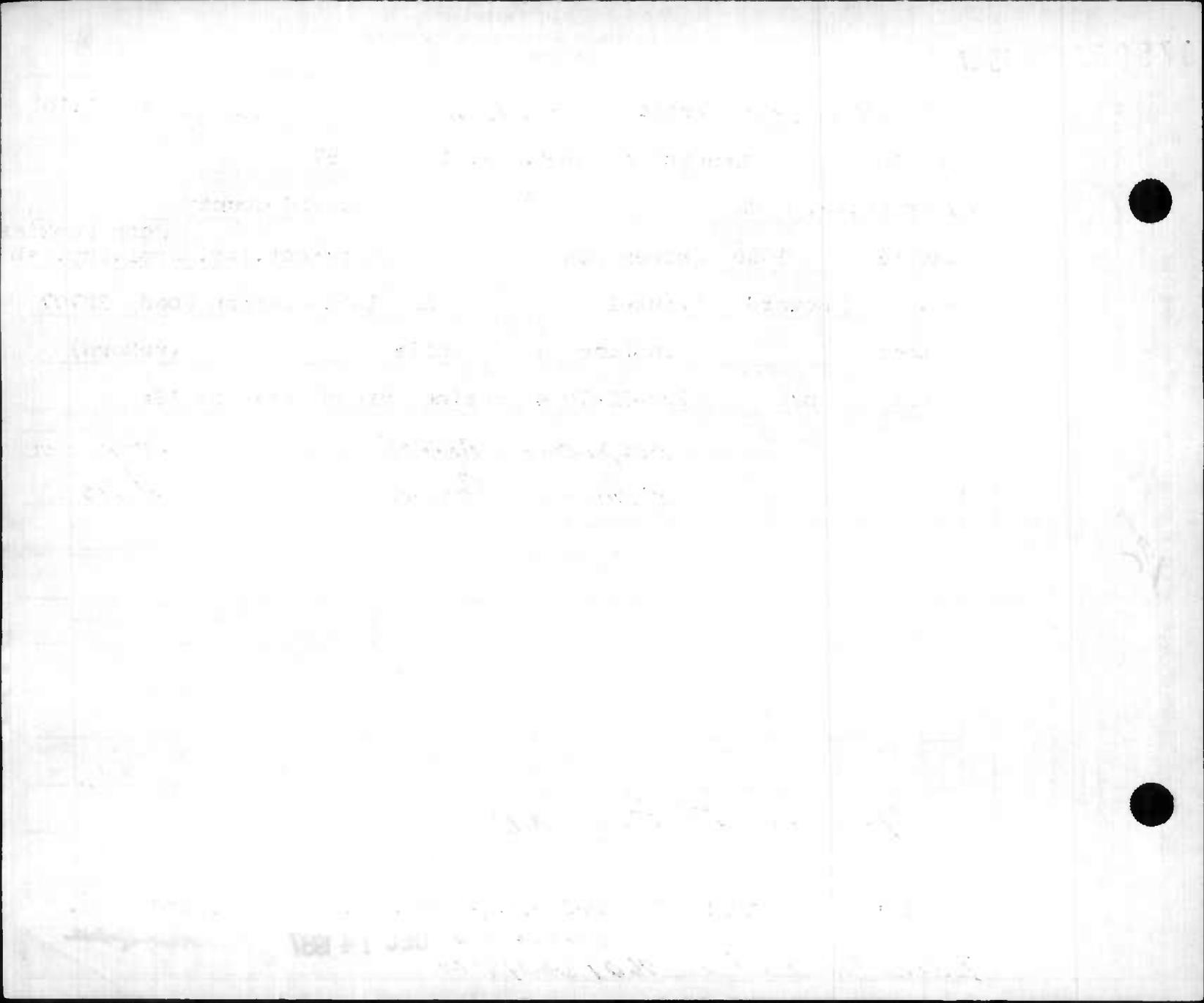
41-21470-2

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8735994
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
<i>Charlotte Marie Purdum</i>						12	10	87		1:10 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
Female		Caucasian		MONTH	DAY	57	YRS	MONTHS	DAYS	IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			10. PLACE OF BUSINESS INDUSTRY	
NewMarket, Va.		US				Howard County			John Hopkins MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. PLACE OF BUSINESS INDUSTRY	
Laurel		10569 Gorman Road				Sup/Acct. Pay. Appl. Phy. Lab				
13a. STATE Md.		13b. COUNTY Howard		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10569 Gorman Road 20707		
14. FATHER'S NAME FIRST Homer		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST Lelia		MIDDLE			LAST (unkown)
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. n/a		17. INFORMANT 230-32-7034 Maurice Purdum same as 13e		ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for item (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. } (b) <i>Ovarian Cancer</i> <i>4 yrs.</i> { DUE TO, OR AS A CONSEQUENCE OF (c) }										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Frederick H. Ben MD</i>		22c. DEGREE		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL 15. <i>Burial</i>		23b. DATE 12/14/87		23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Cem.		23d. LOCATION Jessup Howard Md.		23e. STATE		
24. FUNERAL DIRECTOR NAME <i>Fleck Funeral Home</i>		ADDRESS 7601 SANDY SPR. RD.		25a. DATE REC'D BY CORONER DEC 14 1987		25b. REGISTRATION SIGNATURE				



1-27-88 I.J.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

078110 JAN 138

REG. NO. 15995

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 4/21/1987				2b. HOUR MONTH DAY YEAR	
Jeffrey Allen Ranguette							MONTH	DAY	YEAR	M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS YRS		IF UNDER 1 yr. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
MALE		WHITE		10 14 1966		21 20 yrs						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8c. DATE PRONOUNCED DEAD <input checked="" type="checkbox"/> 12/17/1987				
ILLINOIS				U.S.A.				MONTH DAY YEAR				
10 CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
COLUMBIA				I-95, 1/2 mile South of Rt. #175				12b. KIND OF BUSINESS OR INDUSTRY				
SPECIAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
MICHIGAN				GARDEN				13e. STREET ADDRESS				
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				ADDRESS				
RICHARD RANGUETTE				JO ANN HOLMES				GARDEN, MICHIGAN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				
YES MARINES				368-74-2037				RICHARD RANGUETTE 2190 II ROAD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				19. APPROXIMATE INTERVAL PART 1 DEATH WAS CAUSED BY:				BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a)				Hanging								
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause last.				DUE TO, OR AS A CONSEQUENCE OF								
(b)				DUE TO, OR AS A CONSEQUENCE OF								
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
20a. DATE OF OPERATION				20b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20c. AUTOPSY?				
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 4/21/1987				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) wooded area east				21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject hanged self				
ACTUAL SIGNATURE				THE (TITLE) D.M.D.				MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT)				Dennis F. Smyth, M.D.				DATE SIGNED				
12/18/87				ADDRESS				111 Penn St., Balto., Md. 21201				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORIAL SAC BAY CEMETERY				
BURIAL				23d. LOCATION CITY OR TOWN				FAYETTE, DELTA, MICHIGAN				
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				
MARZULLO FUNERAL SERVICE				WOODSTOCK, MD.				25b. REGISTRAR'S SIGNATURE				
07/94 BP				JAN 12 1988				John J. Marzulli				
DHMH - 17 (VR A15 ME (5))												

68 -

CONCERN

EDITION

800 S. L. MAI

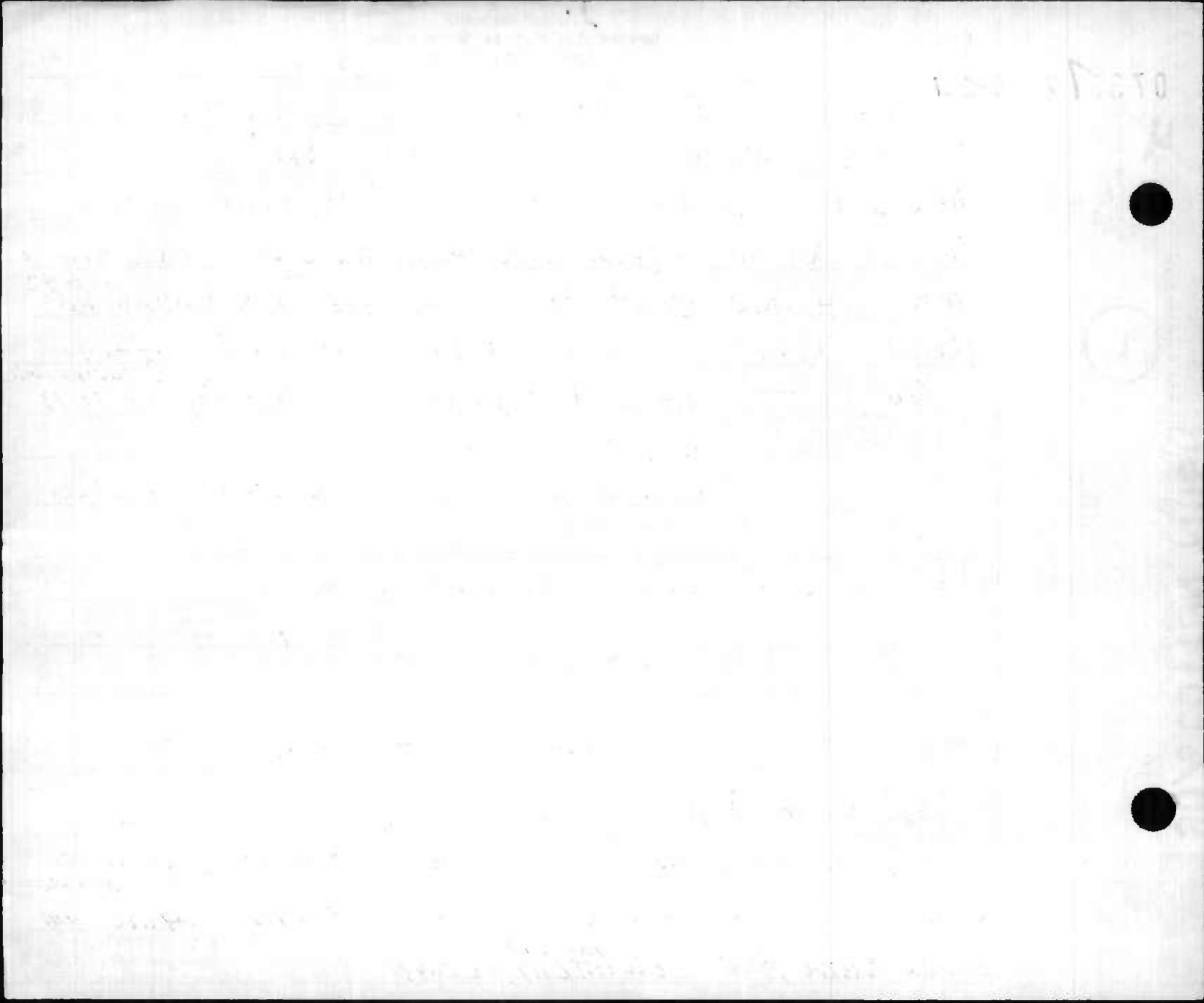
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be filled in by the attending physician and copied onto this certificate.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 22 is checked, any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8735996	
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)	Geraldine E. Rankin			11/30/87	
3. SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS YEARS MONTHS DAYS WEEKS HOURS MINUTES SECONDS AM/PM		
Female	White	1 11 27	60		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.		
Maryland	U.S.A.				
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HCGH (HOWARD Co. Gen. Hosp.)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager	
MD.	13b. COUNTY Howard	13c. CITY OR TOWN Ellicott City	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3352-B N. Chatham Rd. 21043	
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Virgil	Russell	Clark Se.	Ruth	Elizabeth	GARY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. No	17. INFORMANT Eugene Rankin	ADDRESS 3352-B North Chatham Rd. ELLIOTT CITY MD. 21043		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Respiratory Arrest					
DUE TO, OR AS A CONSEQUENCE OF (b) Small cell carcinoma of lung - metastatic 8 months					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Brain metastases, Accid., Acute Renal Failure, Anemia.					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from March 19 87, to Nov 30 19 87, that (I) (we) last saw the deceased alive on Nov 19 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jon K. Minford	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11-30-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jon K. Minford	22e. ADDRESS 10806 Hickory Ridge Rd Columbia, MD 21043				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3 DEC 87	23c. NAME OF CEMETERY OR CREMATORIAL EVERGREEN MEM. GD. FIREBURIAL	23d. LOCATION CITY OR TOWN Columbia, MD	23e. COUNTY Clarendon	23f. STATE MD
24. FUNERAL DIRECTOR NAME SHACK FUNERAL HOME	ADDRESS Box 208 ELLIOTT CITY, MD 21043	25a. DATE REC'D. BY REGISTRAR DEC 03 1987	25b. REGISTRAR'S SIGNATURE Julia Davidson-Lundbeck		

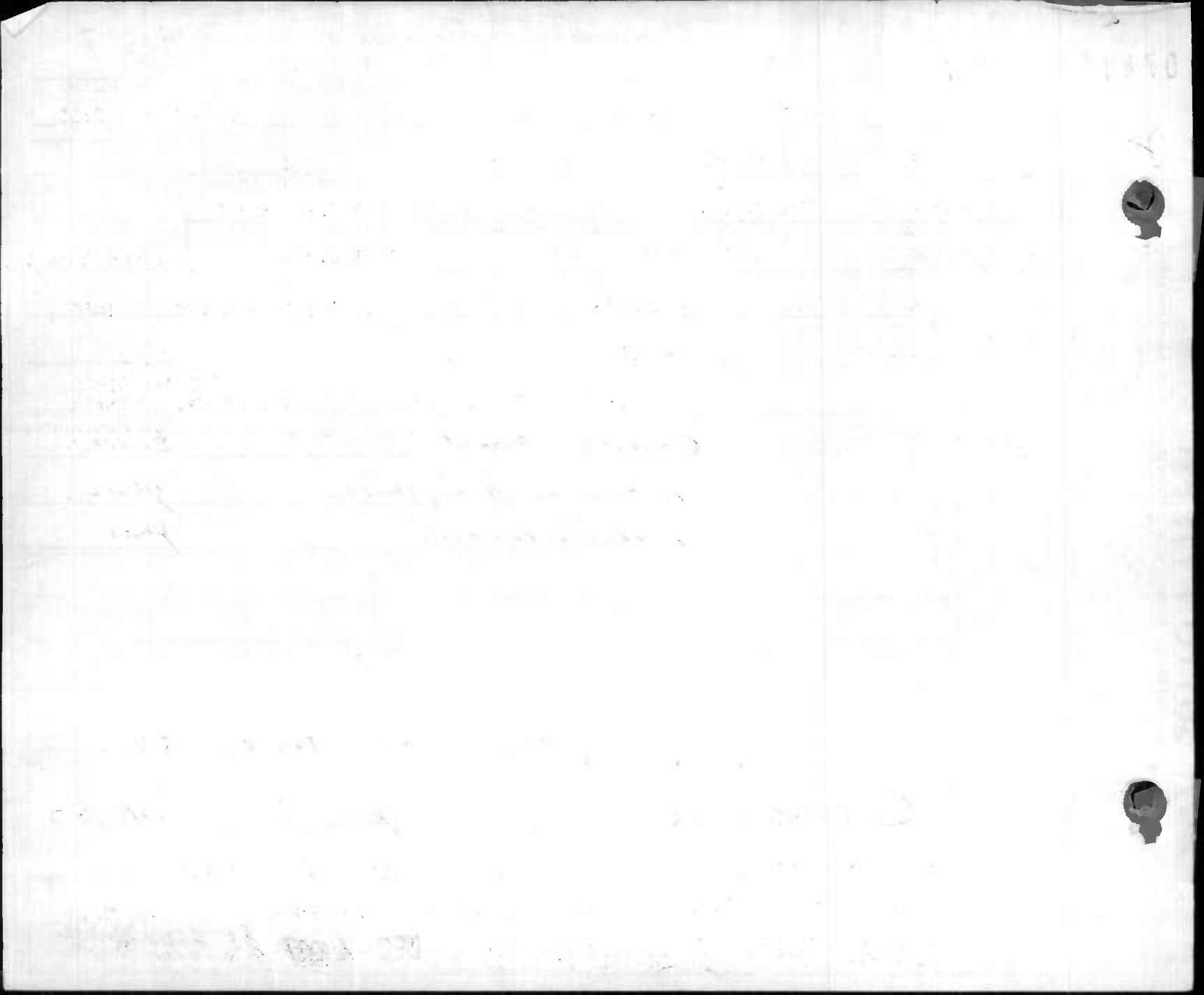


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and family, it should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8735997	REG NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR			
FRANCIS			V.			REILLY						12		02	87	3:55P M				
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH MONTH 01			DAY 14			YEAR 02			6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		IF UNDER 1 YEAR MONTHS		IF UNDER 24 MRS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.											
10. CITY OR TOWN OF DEATH COLUMBIA			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LORIEN NURSING HOME			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN			12b. KIND OF BUSINESS OR INDUSTRY STANDARD & POORS											
13a. STATE MARYLAND			13b. COUNTY HOWARD			13c. CITY OR TOWN COLUMBIA			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 5067 DRY WELL COURT 21045								
14. FATHER'S NAME FIRST MICHAEL			MIDDLE REILLY			15. MOTHER'S MAIDEN NAME ELLEN			16. SOCIAL SECURITY NO. 109-10-2459A			17. INFORMANT ADDRESS HELEN REILLY 5067 DRY WELL CT COLUMBIA MARYLAND 21045								
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Subd. 1 year.</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ventricular fibrillation.</i>								
												DUE TO, OR AS A CONSEQUENCE OF (c) <i>Atherosclerosis</i>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN											
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 19 81</i> to <i>Dec 2 1987</i> , that (I) (we) last saw the deceased alive on <i>Dec 1 1987</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE <i>Jerry Levine</i>						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>12/3/87</i>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JERRY LEVINE						22e. ADDRESS 10802 HICKORY RIDGE COLUMBIA MD														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 12/4/87			23c. NAME OF CEMETERY OR CREMATORIAL WESTVIEW CREMATORIAL			23d. LOCATION CITY OR TOWN BALTIMORE			23e. COUNTY MARYLAND								
24. FUNERAL DIRECTOR LEROY M & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVE CATONSVILLE MD 21228						25a. DATE REC'D. BY REGISTRAR DEC - 4 1987			25b. REGISTRAR'S SIGNATURE <i>John L. Witzke</i>											



075971 DEC 23 1987

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1, 2, 3, SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST				
BURT MILTON									ROWE				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN			
MALE		WHITE		12 15 25		62 yrs.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>			
NEW YORK		U.S.A.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)											
COLUMBIA		5005 GREEN MT. CIRCLE											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		APT. 3			
MARYLAND		HOWARD		COLUMBIA				5005 GREEN MT. CIRCLE		21044			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
MAX				ROSENBLUM		ROSE				KRAMER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		COLUMBIA, MD 21044			
YES		WW II		054-24-6758		JOHANNA ROWE 5005 GREEN MT. CIRCLE APT 3							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>													
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <i>Arteriosclerotic Cardio-vascular Disease</i>													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)		19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Thomas F. Herbert</i>		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER										DATE SIGNED <i>12-21-87</i>	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS <i>Ellicott City MD 21043</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
CREMATION		12/22/87		WESTVIEW CREMATORY		WESTVIEW				BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
LEROY M & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVE CATONSVILLE MD 21228		DEC 22 1987											



RECEIVED

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072188 NOV 18 1987
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

87

35999

REG. NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be retained for use as the burial/transit permit. Then please remove carbon copy pages 1 and 2 should be held within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT)			FIRST REBA	MIDDLE ELAINE	LAST SCHARFF	2a DATE OF DEATH MONTH DAY YEAR 11 16 87	2b HOUR 8:45a M		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 04 30 09		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY			
10. CITY OR TOWN OF DEATH COLUMBIA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7007 FOLDED PALM		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SCHOOL TEACHER		12b KIND OF BUSINESS OR INDUSTRY EDUCATION			
13a. STATE MARYLAND		13b COUNTY HOWARD		13c CITY OR TOWN COLUMBIA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7103 HONEYLADEN 21045	
14. FATHER'S NAME FIRST WILLIAM		MIDDLE HERSHEL		LAST GRANT		15. MOTHER'S MAIDEN NAME FIRST CLARA		MIDDLE LAST CORNELIUS	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 148-30-2947		17 INFORMANT JESSE SCHARFF		ADDRESS MARYLAND 21045		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months.	
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Small cell cancer of lung. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Chronic Anemia, Protein-Calorie malnutrition, Diabetes mellitus									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from Nov 18, 1987, to Nov 19, 1987, that (I) (we) last saw the deceased alive on Nov 19, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jon K. Minford		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 11-16-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JON K. MINFORD MD		22e ADDRESS 10806 HICKORY RIDGE ROAD COLUMBIA, MARYLAND							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 11/18/87		23c NAME OF CEMETERY OR CREMATORIAL BAY VIEW		23d LOCATION CITY OR TOWN BAYVILLE		COUNTY	STATE NEW JERSEY
24 FUNERAL DIRECTOR LEROY M & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVE. CATONSVILLE MD 21228				25a DATE REC'D. BY REGISTRAR NOV 17 1987		25b. REGISTRAR'S SIGNATURE Leander Lendell			

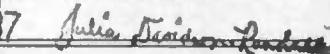
Digitized by srujanika@gmail.com

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

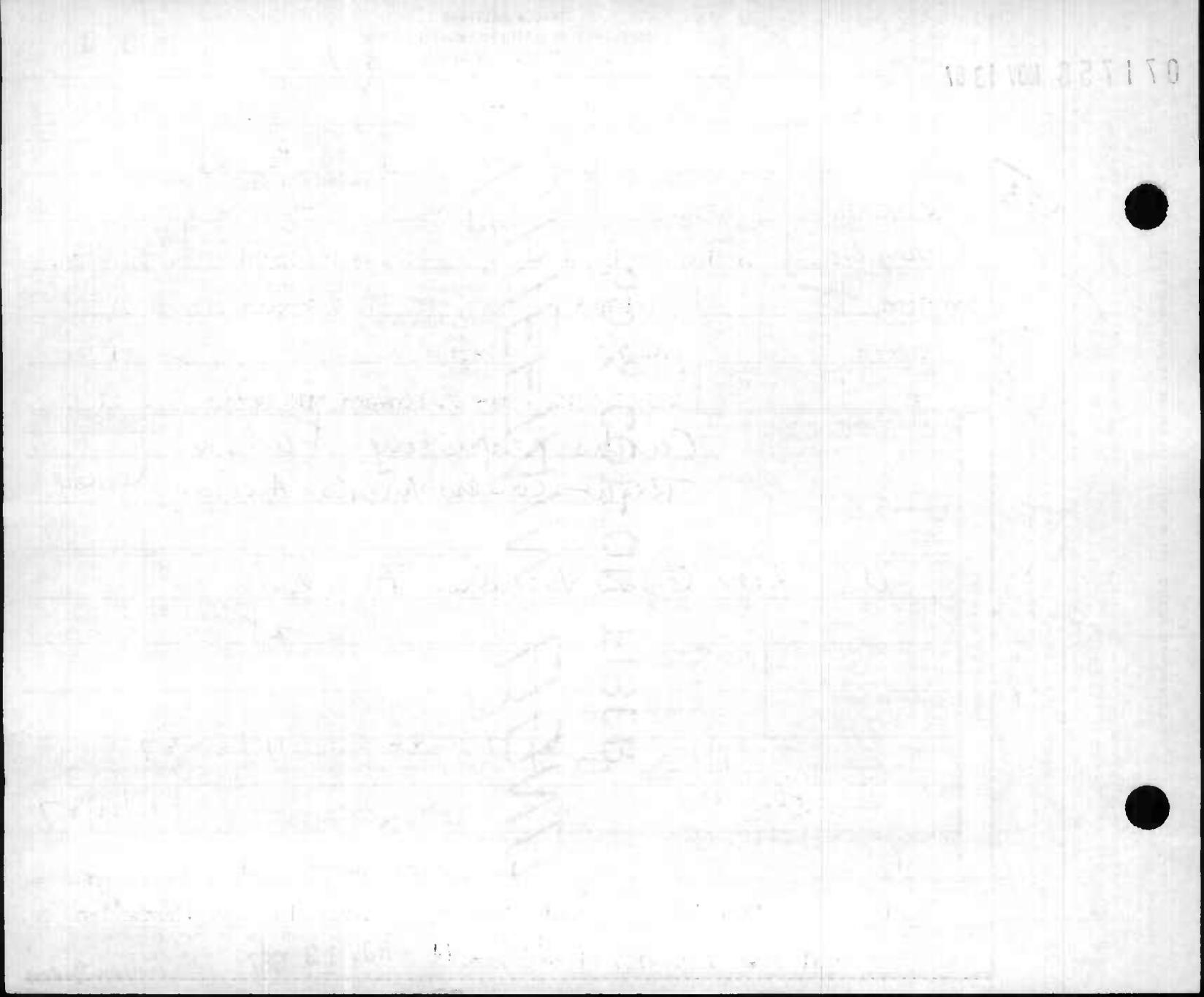
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87	REG. NO. 36000	
DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
3-87 EDITH			MAE		SCOVERN	11 10 87			245 PM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 12 DAY 17 YEAR 04			6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.					
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lorien Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sewing Machine Op. Shirt Co.			12b. KIND OF BUSINESS OR INDUSTRY Aetna					
13a. STATE Maryland		13c. COUNTY Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1937 Sponson Street 21230					
14. FATHER'S NAME FIRST Thomas		MIDDLE FOULDS		15. MOTHER'S MAIDEN NAME FIRST Martha			MIDDLE Miller					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 205-03-2519		17. INFORMANT James F. Scovern 9413 Parsley Dr. 21043			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) Right Cerebro Vascular Accident												
{ DUE TO, OR AS A CONSEQUENCE OF (c) 4 week												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) all life Cerebro Vascular Accident												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/3 1987 , to 11/3 1987 , that (I) (we) last saw the deceased alive on 11/3 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 11/11/87		
22b. SIGNATURE 		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sadig		22e. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/14/87		23c. NAME OF CEMETERY OR CREMATORIAL Shamokin Cemetery			23d. LOCATION CITY OR TOWN Shamokin		COUNTY		STATE Northumberland Pa.	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.		ADDRESS 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR NOV 12 1987			25b. REGISTRAR'S SIGNATURE 					

REC'D VOL 23 T 1 150

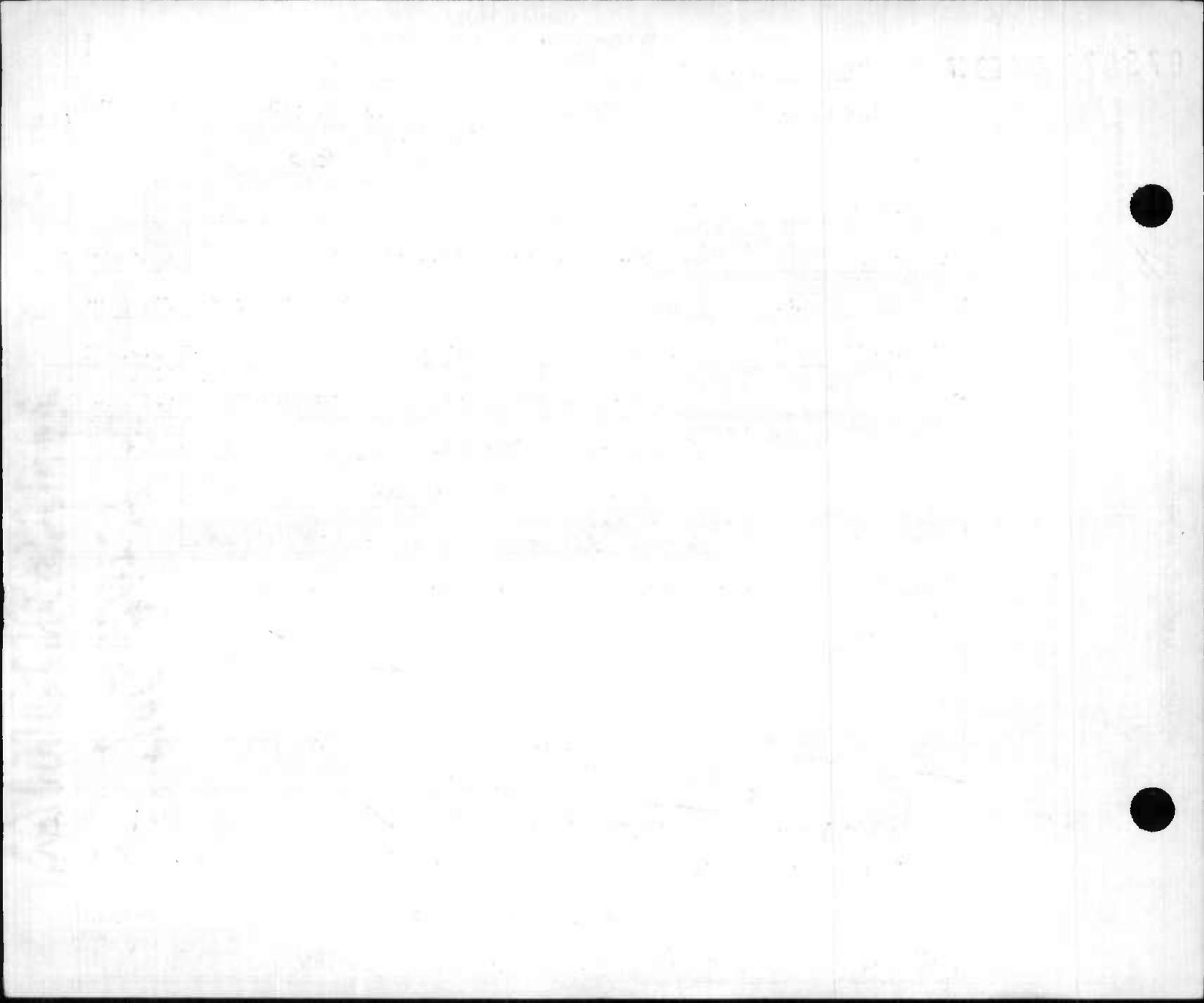


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked 2 it shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 36001	
1. DECEASED NAME (TYPE OR PRINT) MARGARET M. SHORT				2a. DATE OF DEATH MONTH DAY YEAR 12/19/87 12 - 19 - 87				2b. HOUR 3:50 A.M.			
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH MONTH 08 DAY 15 YEAR 07	6 AGE (IN YEARS LAST BIRTHDAY) 80 MONTHS YRS	7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY				MD.				
10 CITY OR TOWN OF DEATH COLUMBIA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD COUNTY GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANAGEMENT				12b. KIND OF BUSINESS OR INDUSTRY TELEPHONE CO.			
13a. STATE MARYLAND	13b. COUNTY HOWARD	13c. CITY OR TOWN COLUMBIA	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6453 POUND APPLE CT. 21045							
14. FATHER'S NAME FIRST THEODORE	MIDDLE LAST LUCAS	15. MOTHER'S MAIDEN NAME FIRST MARGARET	MIDDLE LAST CUMBERLAND								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 212-10-0674	17. INFORMANT PEGGY SHORT	ADDRESS MD. 21045								
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiogenic Shock								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3d			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction								3d			
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic coronary arterial disease											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Hypertension, insulin dependent diabetes mellitus, chronic renal insuff											
19a. RATE OF OPERATION —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET —	CITY OR TOWN —	COUNTY —	STATE —						
22a. I certify that (I) (this hospital) attended the deceased from 12/19/87 to 12/19/87 , that (I) (we) lost saw the deceased alive on 12/19/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE Patrice A. Tole				DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 12/19/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICE A. TOLE				22e. ADDRESS 1072 Hickory Ridge Rd, Columbia 21044							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12/22/87	23c. NAME OF CEMETERY OR CREMATORIAL DRUID RIDGE CEMETERY	23d. LOCATION CITY OR TOWN BALTIMORE	STATE MARYLAND							
24. FUNERAL DIRECTOR LERoy M. & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVE. CATONSVILLE MD 21228	25a. DATE REC'D. BY REGISTRAR DEC 22 1987			25b. REGISTRAR'S SIGNATURE BP							



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8736002
REG. NO.

075007 DEC 15 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

written by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full in the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 26 is blanked out, the medical certification section must be completed.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Wilhelmina					SIMPSON	12/12/87	12	12	87	6 50 A.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 72 HRS			
FEMALE	BLACK	08/06/06	8	06	06	81	81 yrs.	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>									9. BALTIMORE CITY OR COUNTY OF DEATH	
GEORGIA Savannah Ga.	U.S.A.										HOWARD COUNTY	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
COLUMBIA, MD	HOWARD COUNTY GENERAL HOSPITAL									CLERK	N.Y. STATE	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE	MD.					
MARYLAND	HOWARD	COLUMBIA	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	13f. ADDRESS	5415 BISHOPS HEAD COURT	21044					
14. FATHER'S NAME	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE	LAST					
WILL		BRIGHT	ALMA				SNOWDEN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS									
NO	134-09-5192	ALMA SHARPE	COLUMBIA, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>YRS</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____												
DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Diabetes mellitus</u>												
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>1973</u> , 19 <u>87</u> , to <u>12/12</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>12/12</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Charles G Taylor MD</u>	22c. DEGREE MD					ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED <u>12-12-87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Charles G Taylor MD</u>	22e. ADDRESS <u>2 Knoll Park Drive Columbia MD 21045</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE BURIAL 12/17/87	23c. NAME OF CEMETERY OR CREMATORIAL MEMORIES GARDEN	23d. LOCATION CITY OR TOWN ALBANY	COUNTY	STATE							
NEW YORK												
24. FUNERAL DIRECTOR HERROY M & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVE. CATONSVILLE MD 21228	25a. DATE REC'D. BY REGISTRAR DEC 14 1987									25b. REGISTRAR'S SIGNATURE <u>Julia Sanderson-Lindner</u>		

100-18581



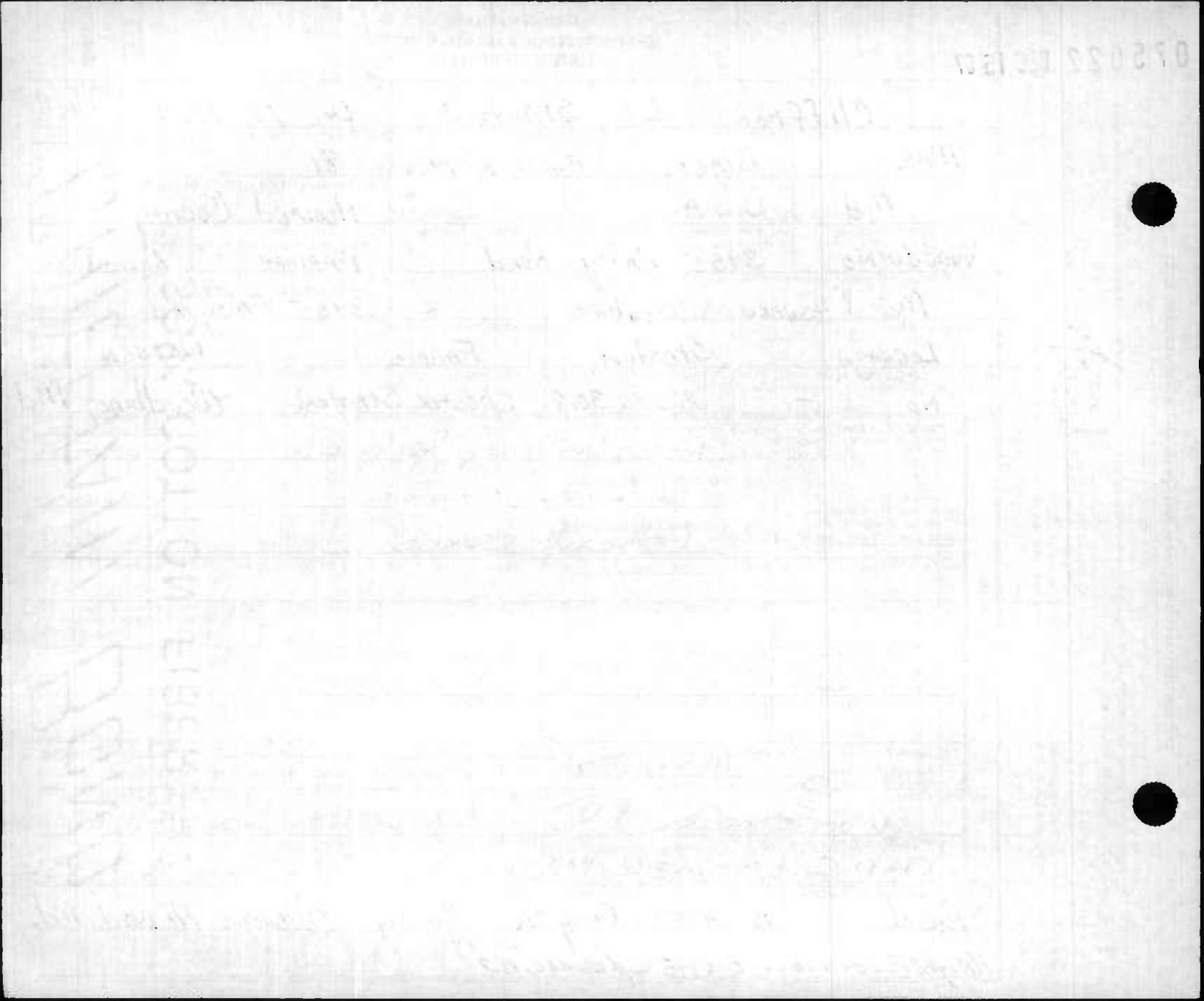
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper, sign page 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 87 36003				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
Clifton L. Stanton						Dec. 10, 1987						9:45 P.M.				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			Black			March 3, 1906			81			MONTHS		DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Md.			U.S.A.									Howard County				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Woodbine			3955 Daisy Road			FARMER						Agriculture				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			ZIP CODE	
Md.			Howard			Woodbine						3955 Daisy Rd.			21797	
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME										
FIRST			LAST			FIRST			LAST			MIDDLE				
Lorenzo			Stanton			Fannie						Dotson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
No			—			22032 3013			Chester Stanton			Woodbine, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(b) Severe anemia															2 days.	
(c) Pneumonia															2 years. 2 + years.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 23, 1987</u> , to <u>Dec 10, 1987</u> , that (we) lost saw the deceased alive on <u>above</u> , (I) (we) did (did not) view the body after death.																
22b. DEGREE															22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS												12/11/87	
John G. Losmeier MD			2901 Oliver Rd - Olney Md 20832													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY				
Burial			12-14-87			Daisy Church Cemetery			Woodbine			Howard			Md.	
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Haight Funeral Home Box 195 Sykesville, MD			21784			JULY 14 1987			Julia Deason			Land				

052083 ECPA



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												87 36004	REG. NO.
1. FOR STATE REGISTRAR			1. RELEASED NAME (TYPE OR PRINT)	1. FIRST	1. MIDDLE	1. LAST	2. DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
			<i>James EATON</i>			<i>STEELE</i>	October 23, 1987			7 ¹⁸ P.M.			
3. SEX			4. RACE			5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			
MALE			WHITE			7 13 07				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY
MASSACHUSETTS			U.S.A.			HOWARD COUNTY			Purchasing Agent			United Illumina.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13c. STREET ADDRESS / ZIP CODE				
COLUMBIA			HOWARD COUNTY GENERAL			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			6336 CEDAR LN, Col. 21044				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			15. MOTHER'S MAIDEN NAME				
MARYLAND			HOWARD			COLUMBIA			FIRST GRACE MIDDLE			LAST BRADLEY	
14. FATHER'S NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) <input checked="" type="checkbox"/> YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE NAME AND DATES) <i>WWII 043-16-3301</i>			17. INFORMANT			ADDRESS	
									SUSAN S. HARDIE			6705 PINE DR. COLUMBIA, MD. 21046	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
						Ventricular Arrhythmia			Immediate				
						DUE TO, OR AS A CONSEQUENCE OF (c)			Atherosclerotic Cardiac Disease			minutes	
												years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.a													
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
			None						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (1) (this hospital) attended the deceased from April 2, 1986, to October 23, 1987, that (1) we last saw the deceased alive on October 23, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) we did (did not) view the body after death.													
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS						10-23-87	
WILLIAM PARNES						1085 LITTLE PATUXENT PKWY, Columbia, MD 21044							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN				
BURIAL			27 OCT 87			ORANGE CEN. CEMETERY			ORANGE			ORANGE	CT
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
SLACK FUNERAL HOME			BOX 268 ELLIOTT CITY MD 21042			NOV 12 1987			Julie Sanderson-Ladouce				

08

37144

Yesterdays

4.2 N

all went well

lunch

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 3 should be used within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification must be completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 87 36005	
1 - STATE REGISTRAR			FAMILY NAME (TYPE OR PRINT)			LAST			DATE OF DEATH MONTH DAY YEAR			2b HOUR	
10-87 RELEASER NAME (TYPE OR PRINT)			William L. Sulzbacher			Sept. 11 1913			Nov. 4th 1987			4:15 P.M.	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 11 1913		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Braddock, Pa.		7b. CITIZEN OF WHAT COUNTRY? US		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Howard		10a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chem.&Bio(Ret) Dept. Agri.		12b. KIND OF BUSINESS OR INDUSTRY MD.			
10 CITY OR TOWN OF DEATH Fulton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8527 Clarkson Drive		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 8527 Clarkson Dr. 20759							
13a. STATE Md.		13b. COUNTY Howard		13c. CITY OR TOWN Fulton		15 MOTHER'S MAIDEN NAME FIRST Ethel MIDDLE LAST Fisher							
14. FATHER'S NAME FIRST Henry MIDDLE LAST Sulzbacher		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) n/a		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a 210-07-7569		17. INFORMANT Dorothy Sulzbacher		ADDRESS same as 13e					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) UREMIA DUE TO, OR AS A CONSEQUENCE OF (b) END STAGE RENAL DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROSIS												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 60 DAYS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/3 1982 to 11/4 1987 , that (I) (we) last saw the deceased alive on 10/29 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>James F. Winchester MD</i>		22c. DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 11/6/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES F WINCHESTER		22e. ADDRESS GEORGETOWN UNIVERSITY DC											
23a. BURIAL, CREMATION, REMOVAL Cremation		23b. DATE 11/6/87		23c. NAME OF CEMETERY OR CREMATORIAL Biamo Wash. Crematory Laurel		23d. LOCATION Laurel		P.O.B. P.O. Box 116		STATE Md.			
24 FUNERAL DIRECTOR NAME Fleck Funeral Home, Inc. ADDRESS 7601 Sandy Spring Rd. Laurel, Md. 20701		25a. DATE REC'D. BY REGISTRAR NOV 09 1987				25b. REGISTRAR'S SIGNATURE <i>Julie Dearden-Purcell</i>							

075927

#13e, FilmG636 2/5/88 kam

FOR
STATE
REGISTRAR
OCT 12 1987STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

REG NO.

36006

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
WALTER C. SWEIKHART						12-18-87				1:45AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Male		CAUCASIAN		12 - 01 - 05		82 yrs				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Wash. D.C.		USA						Howard		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY				
Columbia		Lorien Nursing Home & Care				Retire Iron worker				
13a STATE Maryland		13b COUNTY Howard		13c CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 4037 Jayne Court 21043		
14. FATHER'S NAME FIRST Otto Sweikhart		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST Jannette D'Alaboro		LAST		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. 579 03 3674		17 INFORMANT Jannette Lawrence 711 Covington Ct Sykesville		ADDRESS 21784				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Vasculitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>-</u> DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2mo 4 yrs				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>Carcinoma of prostate</u>										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1983, 19, to 12-18, 19, 87, that (II) (we) last saw the deceased alive on 12-8, 19, 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (II) (we) did not view the body after death.										
22b. SIGNATURE <u>Richard W. Smith M.D.</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-18-87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard W. Smith M.D.		22e. ADDRESS 10802 Hickory Ridge Rd. Columbia, md. 21046								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 19, 1987		23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park		23d. LOCATION CITY OR TOWN Baltimore		COUNTY Maryland	STATE	
24 FUNERAL DIRECTOR NAME Harry H Witzke \$112 Old Columbia Pike Ellicott		ADDRESS		25a. DATE REC'D. BY REG. AR'D. REG. NO. DEC 22 1987		REGISTRATION SIGNATURE				

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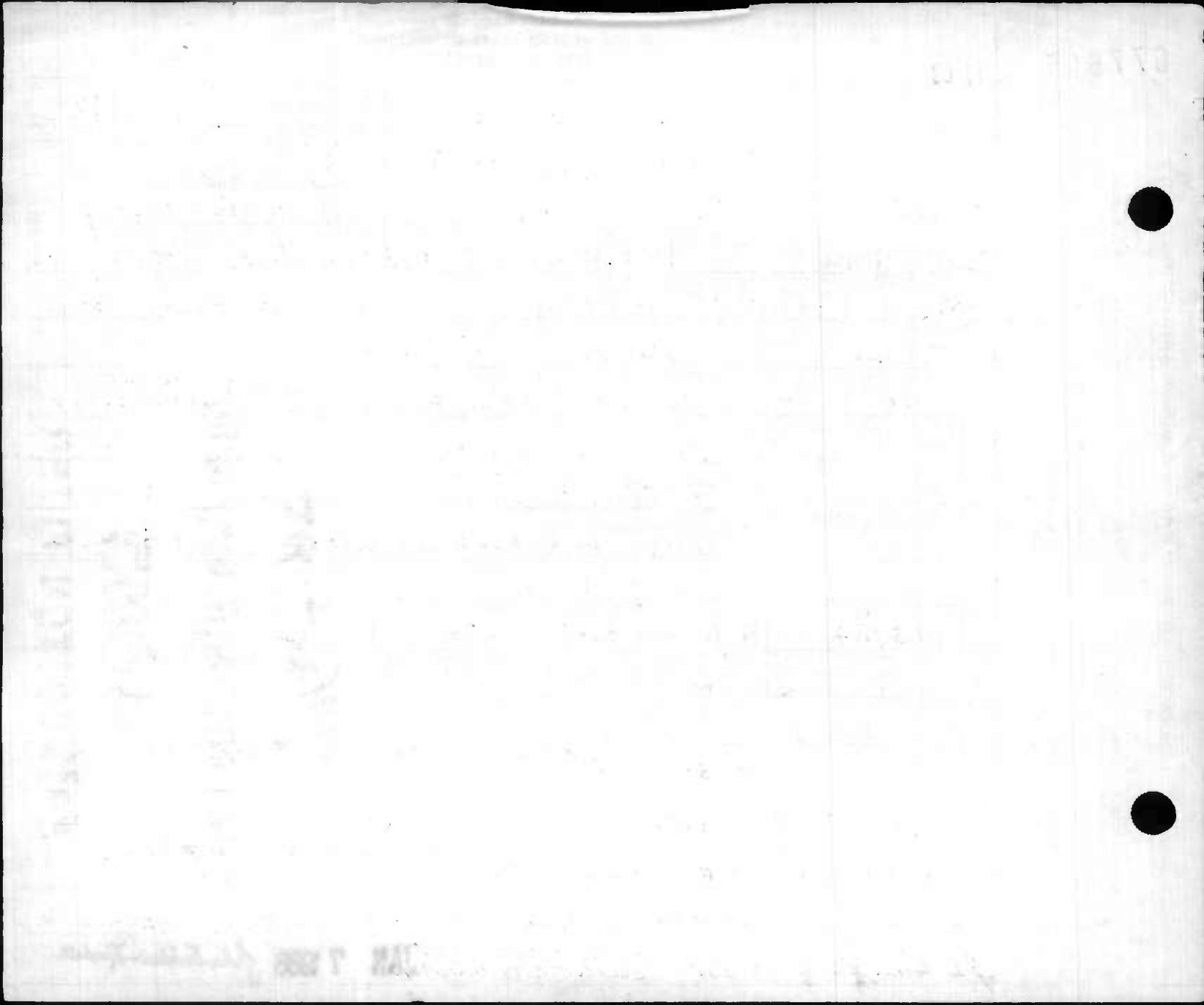
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner may be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87	REG. NO.	6007
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Sylvia					Thompson	NOV.	27		1987	12:40 PM		
3. SEX			4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR			
Female			Black	NOV. 27 1906	81				MONTHS	DAYS	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			MD				
FLORIDA			US		Howard County							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Columbia			HCGH (Howard Co. Gen. Hosp.)			HEAD CHEF			TRANSWAYS BUS.			
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE						
MD			Howard	Columbia		5430 OLD WATERLOO RD 21045						
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						
Thomas					BARNES	KATHERINE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
NO			261-05-1108			Wm M. Thompson			10900 KATHLEEN CT. COLUMBIA, MD. 21044			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
—												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bilateral Cerebrovascular accident</u> 5 weeks												
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Perforated duodenal ulcer</u> 6 weeks												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Congestive heart failure</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
11/18/87			Perforated duodenal ulcer									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/18/87</u> , 1987, to <u>12/30/87</u> , 1987, that (I) (we) last saw the deceased alive on <u>12/30/87</u> , 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Bernard P. Farrell MD</u> DEGREE												
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS <u>11055 Little Patent PKwy</u> <u>Columbia, MD 21044</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22f. DATE SIGNED <u>12/30/87</u>			
BERNARD P. FARRELL MD												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <u>4 JAN 88</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>ST. JOHN'S CEMETERY</u>			23d. LOCATION CITY OR TOWN <u>ELLIOTT CITY</u> COUNTY <u>HOWARD MD.</u> STATE			
BURIAL												
24. FUNERAL DIRECTOR NAME <u>John Dallas Slack #100535</u>			25a. DATE REC'D. BY REGISTRAR <u>JAN 7 1988</u>			25b. REGISTRAR'S SIGNATURE <u>June Davidson Pendleton</u>						

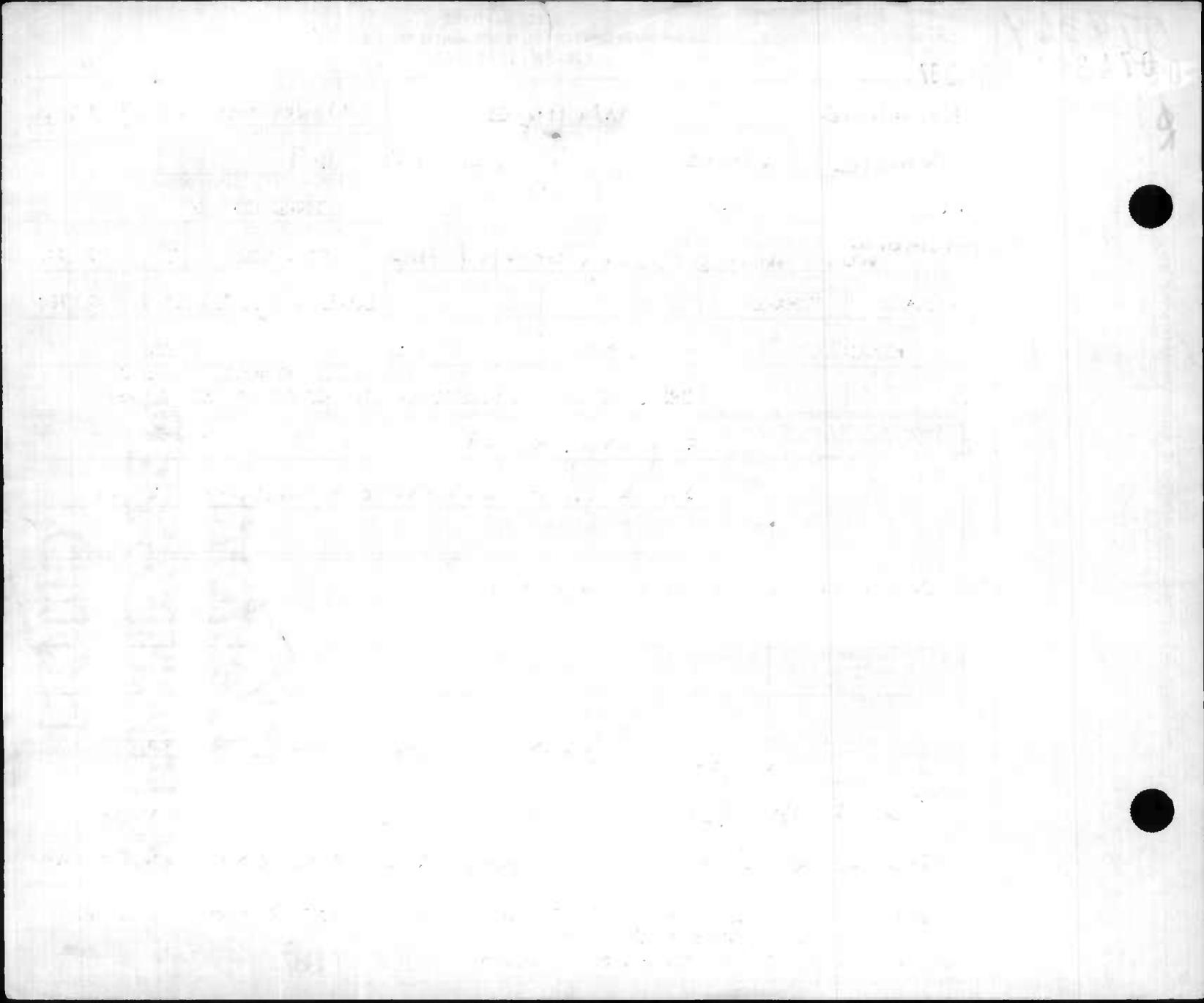


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1 - STATE REGISTRAR			FIRSt			MIDDLE			LAST				
1. DECEASED NAME (TYPE OR PRINT)			Wallace						2a DATE OF DEATH MONTH DAY YEAR				
Rosalind									87 REG. NO. 36008				
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 9 22 1918			6. AGE (IN YEARS LAST BIRTHDAY) 69 yrs				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.				
10. CITY OR TOWN OF DEATH COLUMBIA MD.			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD County General Hsp			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SOC. WORKER			12b. KIND OF BUSINESS OR INDUSTRY BOARD OF ED.				
13a. STATE MARYLAND			13b. COUNTY HOWARD			13c. CITY OR TOWN COLUMBIA			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME FIRST EMMANUEL			MIDDLE SEIDLER			15. MOTHER'S MAIDEN NAME FIRST IDA			LAST JAFFE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 383-38-2118			17. INFORMANT MR. ALLAN WALLACE 10065-3 WINDSTREAM DR. COLUMBIA, MD 21044			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Breast Cancer - metastatic to lungs, liver, 5 yrs DUE TO, OR AS A CONSEQUENCE OF (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Chronic anemia Asides Hypertension.													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN				
22a. I certify that (I) (this hospital) attended the deceased from March 19 86 to Nov 19 87, that (I) (we) last saw the deceased alive on Nov 21 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE John K. Minford			DEGREE MD			22c. DATE SIGNED 11-30				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John K. Minford.			22e. ADDRESS 10806 Hickory Ridge Rd Columbia 21047										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE DEC. 1, 1987			23c. NAME OF CEMETERY OR CREMATORIAL OHEB SHALOM MEM. PARK			23d. LOCATION CITY OR TOWN REISTERSTOWN				
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD			25a. ADDRESS 21215			25b. DATE REC'D. BY REGISTRAR DEC - 7 1987			25c. REGISTRAR'S SIGNATURE Julie Leibson - Minford				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon papers from item 2 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be informed of these.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
87 REG. NO. 36009															
1. DECEASED NAME (TYPE OR PRINT)			FIRST			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
<i>Ruby E. Ward</i>									12 13 87			2:05 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 1 HR HOURS MIN.			
Female		Cauc.		12 07 03			84								
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Canada		Canada					<i>Howard</i>			MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE IF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Columbia		Howard County Hospital					Housewife			120901					
13a. STATE Md.		13b. COUNTY Mont		13c. CITY OR TOWN S.S.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 909 Northwest Drive					
14. FATHER'S NAME Thomas		MIDDLE		LAST McBrien			15. MOTHER'S MAIDEN NAME Charlotte Marshall								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? N/A		16b. SOCIAL SECURITY NO. 216-10-2313		17. INFORMANT 15401 Mt. Oak Rd., Mitchelville, Md. Mervin C. Ward (Son)											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Artery Disease</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yr.			
DO TO, OR AS A CONSEQUENCE OF (b) <i>Sepsis</i>												days			
DO TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <i>Cerebrovascular Accidents</i>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/13/87 to 12/13/87, that (I) (we) last saw the deceased alive on 12/13/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body before death.															
22b. SIGNATURE <i>B.H. Minchew, M.D.</i>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>B.H. Minchew</i>		22e. ADDRESS 2850 N. Ridge Rd. Ellicott City, Md. 21043													
23a. BURIAL, CREMATION, REMOVAL SPECIAL Burial		23b. DATE 12/17/87		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Ft. Lincoln			23d. LOCATION CITY OR TOWN Brentwood			23e. PG		Md. STATE			
24. FUNERAL DIRECTOR Hines Rinaldi 11800 New Hamp. Ave. S.S. Md.		25a. DATE REC'D. BY REGISTRAR DEC 15 1987		25b. REGISTRATION SIGNATURE <i>J. L. Johnson</i>											
BP															
DHMH - 16 60M 7/84 (VRA 15, 4)															

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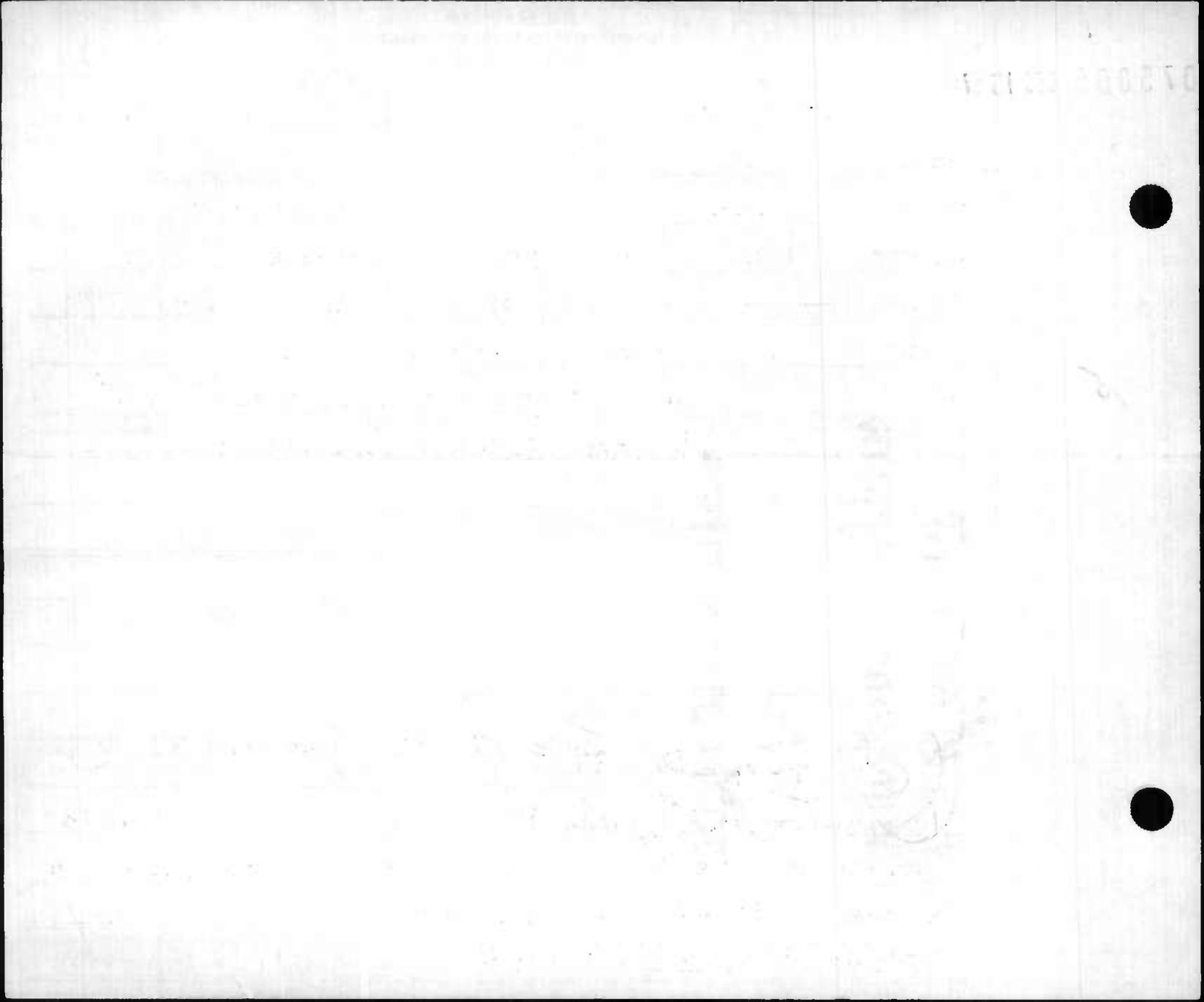
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
87 REG. NO. 36010													
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
BETTY ANN WEBER						12 11 87			9:30am				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
FEMALE		WHITE		11 09 26			61 YRS						
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD			
MARYLAND		U.S.A.					HOWARD COUNTY						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
WOODSTOCK		10626 BREEZEWOOD DRIVE					SUPERVISOR			ARMY			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		21229		
MARYLAND				BALTIMORE					16 N. TREMONT ROAD				
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME									
DANIEL		J.		CATHERINE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO		216-20-2617		THERESA WEBER 10626 BREEZEWOOD DRIVE 21163			WOODSTOCK MD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC BREAST CARCINOMA													
DUE TO, OR AS A CONSEQUENCE OF (b)													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 1c OR PART II									
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT PLAY <input type="checkbox"/> OTHER <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
21g. I certify that (I) this hospital attended the deceased from JUNE 17 1986 to DECEMBER 11 1987, that (I) never saw the deceased alive after JUNE 20 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) was (we) did not view the body after death.													
21h. SIGNATURE				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		21i. DATE SIGNED					
22a. PHYSICIAN'S NAME (TYPE OR PRINT)				MD				12/11/87					
DR. DIANA GRIFFITHS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		COUNTY		STATE		
BURIAL		12/14/87		NEW CATHEDRAL CEMEMTORY			BALTIMORE				MARYLAND		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE						
LEROY M & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVE. CATONSVILLE MD 21228		DEC 14 1987					Julia Denison Reader						

44-1881-10000-V



073145 NOV 25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 and 4 should be attached to the burial permit. Then please return to the funeral director. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, removal, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other than natural event, the medical examiner must be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
87 36011 REG. NO.											
DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
EMMA E. WILSON						11/14/87				11:29A	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Female		Black		MONTH	DAY	YEAR	87			IF UNDER 24 HRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
MD		U.S.A.					Howard				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Columbia		Howard County General Hospital			Domestic			20877			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE			
MD		Montgomery		Gaithersburg		YES <input type="checkbox"/> NO <input type="checkbox"/>		376 N. Summit Ave #101			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						
		William	E.	Frazier	MARY A. JOHNSON						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO		213-34-4430		James J. Frazier (Bro.)			same as #13			24 hours	
18 CAUSE OF DEATH (Enter only one cause per line for 18, 1b), and 1c: PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ Acute intestinal infarction											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ Due to, or as a consequence of Diffuse atherosclerotic vascular disease											
(c) _____ Due to, or as a consequence of uncertain											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Acute Renal Failure											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
11/14		Abdominal Crisis			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/14/87 to 11/14/87, that (I) (we) last saw the deceased alive on 11/14/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		SCOTT MAURER MD			DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		SCOTT MAURER MD			22e ADDRESS			11/14/88			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE
Burial		11-18-87		Brooke Grove Cem.			Gaithersburg, Montg., MD				
24. FUNERAL DIRECTOR NAME		George R. Snowden			ADDRESS	Rockville MD 20850	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
							NOV 19 1987		Julia Snowden-Rublee		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completed, it should be detached for use at the burial-transit point. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8736012	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR				
William Harold Wilson						11/11/87			303p M				
3. SEX male		4. RACE cau		5. DATE OF BIRTH MON 31/18			6. AGE (IN YEARS LAST BIRTHDAY) 69		IF UNDER 1 YEAR YRS.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE WVA		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Howard		MD.				
10 CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lorien Nursing/Rehab Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic			12b KIND OF BUSINESS OR INDUSTRY Bethlehem Steel						
13 STATE Maryland		13b COUNTY Anne Arundel		13c. CITY OR TOWN Millersville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 611 Water Wheel Lane, Apt. 14				
14 FATHER'S NAME FIRST MIDDLE LAST Grover Cleveland Wilson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Butts											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 235-12-1869		17. INFORMANT ADDRESS Dora F. Wilson Millersville, MD 21108									
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arrhythmia(ventricular)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriovenous cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>High blood pressure -</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>multi-infarct dementia, diabetes mellitus, chronic renal failure</u>													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>11/10/87</u> , 19 <u>87</u> , to <u>11/11/87</u> , 19 <u>87</u> , that (I) (we) lost now the deceased alive on <u>11/11/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												22b. DATE SIGNED <u>11/12/87</u>	
22b. SIGNATURE <u>Kolodru BEZ</u>		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>11/12/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Kolodru BEZ MD</u>		22e. ADDRESS <u>2800 Bedford Suite 103</u> <u>Ellicott City, MD 21043</u>			23a. BURIAL, CREMATION, REMOVAL 1. SPECIFY Burial		23c. NAME OF CEMETERY OR CREMATORIAL Mt. View Cemetery			23d. LOCATION CITY OR TOWN Inwood		COUNTY Berkeley	STATE WV
24. FUNERAL DIRECTOR <u>Charles M. Brown</u> Brown Funeral Home		23b. DATE 1/15/87			23c. ADDRESS 327 W. King St. POBox821 Martinsburg, WV 25401			25a. REG'D. BY REC'D. BY REGISTRAR NOV 18 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Jackson-Lindner</u>			

WAC 100-SECT 10

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36013

FOR
STATE
REGISTRAR

I. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Todd

Alan

Zink

2a. DATE KNOWN
OF
DEATH
ESTI-
MATED

MONTH DAY YEAR
11-5 19 87

2b. HOUR
M

3. SEX
MALE

4. RACE
WHITE

5. DATE OF BIRTH
MONTH DAY YEAR
05 30 69

6. AGE (IN YEARS
LAST BIRTHDAY)
18 YRS.

7. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
MARYLAND

IF UNDER 1 YR.
MONTHS DAYS HOURS MIN

8. MARRIED NEVER MARRIED
WIDOWED DIVORCED

2c. DATE
PRONOUNCED
DEAD

MONTH DAY YEAR
11-5 19 87

2d. HOUR
M

9. CITY OR TOWN OF DEATH
COLUMBIA

10. CITIZEN OF WHAT COUNTRY?
U.S.A.

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
road off Little Patuxent Parkway

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
UNEMPLOYED

12b. KIND OF BUSINESS
OR INDUSTRY
N/A

13a. STATE
MARYLAND

13b. COUNTY
HOWARD

13c. CITY OR TOWN
COLUMBIA

13d. INSIDE CITY LIMITS?
YES NO

13e. STREET ADDRESS
10718 CORDAGE WALK 21044

14. FATHER'S NAME
JAMES

MIDDLE
N.

LAST
ZINK

15. MOTHER'S MAIDEN NAME
RUTH

MIDDLE
K.

LAST
HOLLAND

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
NO 215-64-8665

17. INFORMANT
RUTH ZINK

ADDRESS
10718 CORDAGE WALK

MD 21044
COLUMBIA

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carbon Monoxide Intoxication

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES NO

21a. EXTERNAL CAUSE WAS
UNDERLYING OR
CONTRIBUTING CAUSE OF DEATH

21b. TIME OF INJURY found at
HOUR MONTH DAY YEAR
9:15 P.M. 11-5 1987

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

subject inhaled exhaust fumes from auto

21d. INJURY OCCURRED
WHILE NOT WHILE
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)
in auto

21f. LOCATION
STREET
CITY OR TOWN
COUNTY
STATE
road off Little Patuxent Pkwy., Howard Co., Md.

22a. I certify that I took charge of the remains described above, held on
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

Autopsy Inspection Inquiry and in my opinion
TITLE (SPECIFY)
M.D. Dennis F. Smyth, M.D. MEDICAL EXAMINER

DATE
SIGNED 11-6-87

ACTUAL
SIGNATURE Dennis F. Smyth, M.D.

EXAMINER'S NAME
(TYPE OR PRINT)

Dennis F. Smyth, M.D.

ADDRESS 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

CREMATION

23b. DATE
11/07/87

23c. NAME OF CEMETERY OR CREAMATORY
WESTVIEW CREMATORIAL

23d. LOCATION
CITY OR TOWN

COUNTY STATE
CATONSVILLE BALTIMORE MD

24. FUNERAL DIRECTOR

LEROY M & RUSSELL C WITZKE FUNERAL HOMES
1630 EDMONDSON AVE CATONSVILLE MD 21228

25a. DATE REC'D. BY REGISTRAR
NOV 09 1987

25b. REGISTRAR'S SIGNATURE
Richard Pendle

031307 00100

NOV 8 1981